NORTH DAKOTA INTEGRATED HIV & VIRAL HEPATITIS PREVENTION AND CARE PLAN/STATEWIDE COORDINATED STATEMENT OF NEED, 2017-2021

NORTH DAKOTA DEPARTMENT OF HEALTH, DIVISION OF DISEASE CONTROL

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NORTH DAKOTA COMMUNITY PLANNING GROUP FOR HIV AND VIRAL HEPATITIS PREVENTION

NORTH DAKOTA DEPARTMENT of HEALTH

North Dakota Department of Health HIV·STD·TB VIRAL HEPATITIS PROGRAM

North Dakota CPG Community Planning Group for HIV & Viral Hepatitis Prevention Care and Treatment

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SECTION I: STATEWIDE COORDINATED STATEMENT OF NEED/NEEDS ASSESSMENT

Epidemiologic Overview

Introduction

The Epidemiologic Profile of HIV and Viral Hepatitis describes the epidemiology of HIV/AIDS, hepatitis B, and hepatitis C in North Dakota during the year of 2015. This profile covers the general epidemiology of diseases in terms of gender, age, race, geography, and associated casual factors. This profile was created to assist in developing a Comprehensive Jurisdictional Prevention and Care Plan. Information in this report is used to characterize and predict the changing epidemic at the local level. North Dakota data are summarized annually to help North Dakota's Department of Health answer questions of how to prevent these diseases in the population. Four sections focused around answering four key questions will be covered in this document:

- What are the socio-demographic characteristics of North Dakota's population?
- What is the epidemiology, including the geographical distribution, of HIV/AIDS and viral hepatitis in North Dakota?
- What are the patterns of utilization of services throughout the state?

HIV and Viral Hepatitis Epidemiology in North Dakota

What are the socio-demographic characteristics of North Dakota's population?

This section provides background information about North Dakota's population. The purpose is to provide a context for assessing the potential impact of HIV/AIDS, sexually transmitted disease, tuberculosis and viral hepatitis.

Section Highlights

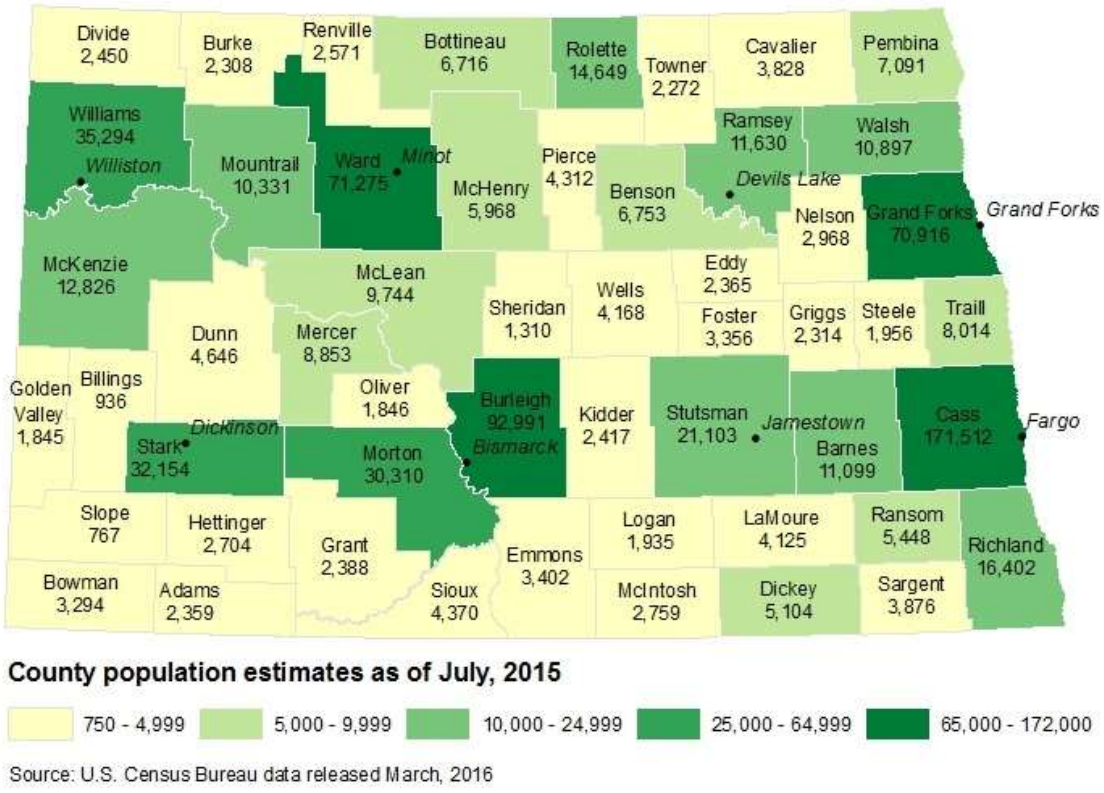
The 2015 census from the U.S. Census Bureau indicates that there are 756,927people residing in North Dakota, ranking it 48th in the nation in population. Eight-six percent of the total population is white, non-Hispanic and approximately 14percent are of other racial or ethnic minority groups.

The eight most populous counties of Ward, Burleigh, Cass, Grand Forks, Stark, Williams, Stutsman, and Morton account for 69 percent of the total population of North Dakota.

North Dakota Demographics

North Dakota is a rural state that covers 70,704 square miles and in 2015 had a population of 756,927, according to the U.S. Census Bureau. North Dakota ranks 47th in the nation by population. It contains 53 incorporated counties; 13 cities have populations above 10,000; 33 cities have populations above 2,500. County populations in North Dakota range from 767 to 171,512 people. The six counties along the eastern border with Minnesota account for over one-third of the state's population.

Figure 1. Major cities and county population estimates of North Dakota, 2015

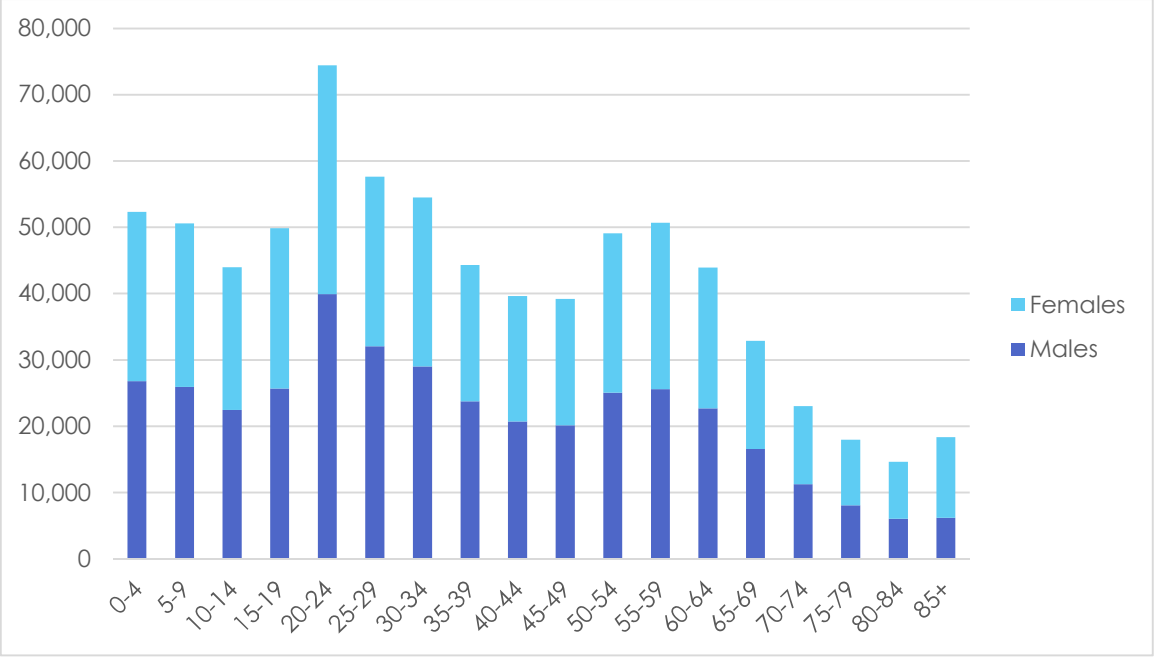


Source: U.S. Census Bureau data released March, 2016

Age and Gender Distribution

At the time of the 2015 U.S. Census, North Dakota's population was 51 percent male and 49 percent female, a distribution that has been consistent for at least six years. Over one quarter of North Dakota's population is over the age of 55. Of the remaining 75 percent, adults ages 20 to 24 are disproportionality represented. Within that group, there are 15 percent more males than females. The largest discrepancy between males and females are between the ages of 25 and 29, where there are 25 percent more males than females.

Figure 2. North Dakota population by age group and gender, 2015



Race Distribution

The majority of North Dakota's population reports white (89.6 percent) as their race. The largest minority group is America Indian and Alaskan Natives, accounting for 5.4 percent, most of whom reside in Rolette and Sioux counties. The African American/Black population follows, accounting for an estimated 1.8 percent of the total population.

Figure 3. North Dakota population by race, 2014

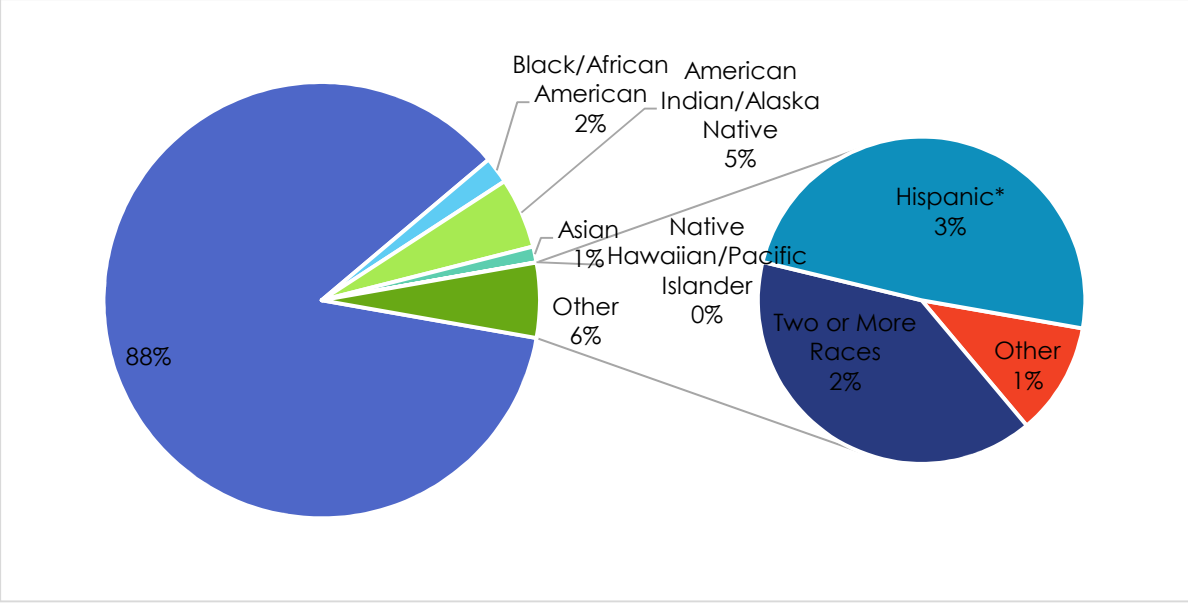


Table 1. North Dakota population by race, 2014

2014 North Dakota Population by Race	Number	Percent
White, alone	654,375	88 %
Black/African American	14,910	2 %
American Indian/Alaska Native	39,669	5 %
Asian	8,899	1 %
Native Hawaiian/Pacific Islander	173	0 %
Other	4,680	1 %
Two or More Races	16,776	2 %
Hispanic*	20,618	3 %

*Hispanics may be of any race and are also included in other applicable race categories

Social Characteristics

The social characteristics of North Dakota include education, place of birth, and poverty level. A majority (90.9 percent) of the population age 25 and older had graduated from high school, according to 2014 census estimates. The percent of the population born in a country other than the United States is 2.7 percent. Nearly 88,000 (11.9 percent) of individuals live on wages below the federal poverty level. For a household of one, that equates to approximately $11,490 per year.

HIV and Viral Hepatitis Epidemiology in North Dakota

This section will present data on who is infected, how they became infected, where cases are occurring, and how this may be changing over time.

Section Highlights

HIV

In 2015, 30 new HIV/AIDS cases were diagnosed in North Dakota; the highest ever reported In North Dakota since HIV reporting began in 1984.

Diagnoses of HIV and AIDS occurred mostly among males in 2015; the age range for newly diagnosed HIV cases in males was 19 to 63, with relatively even distribution across age ranges.

The median age at diagnosis of HIV for newly diagnosed cases in North Dakota was 34 in 2015.

Men who have sex with men (MSM) remains the predominant risk category. In 2015, 30 percent of all new diagnoses reported MSM as a risk factor for infection.

New cases are no longer clustered in population centers in North Dakota, but are seen in most regions of the state.

Viral Hepatitis

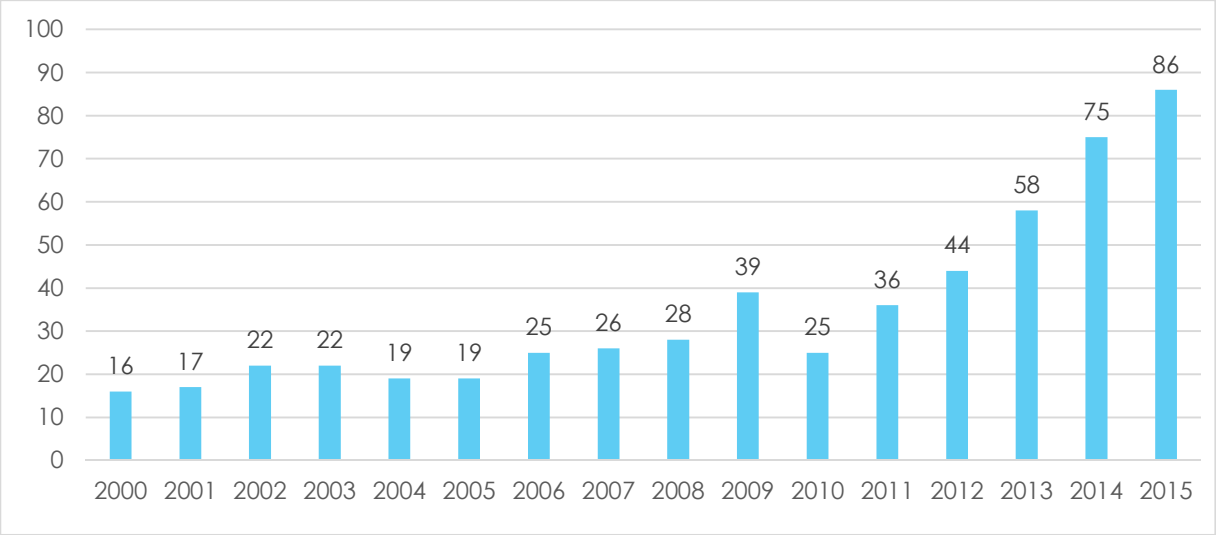
In 2015, 99 cases of Hepatitis B (HBV) infection and 1,063 reports of past or present Hepatitis C (HCV) were reported.

Human Immunodeficiency Virus (HIV)

Total Reported Cases of HIV Infection

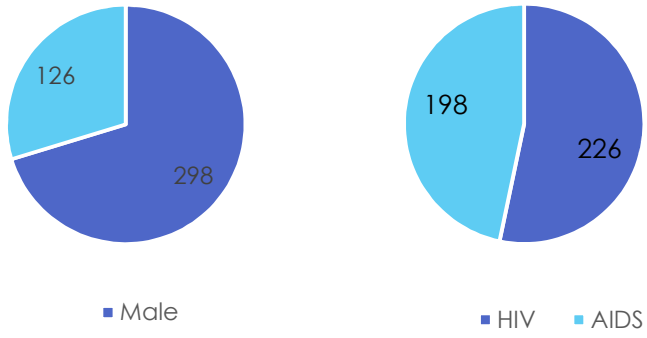
There were 86 reported cases of HIV/AIDS in North Dakota in 2015. Figure 4 shows the number of cases new to North Dakota since 2000. This includes not only cases newly diagnosed in North Dakota, but also persons who moved into the state with an established infection during the year. HIV/AIDS has been a reportable condition in North Dakota since 1984.

Figure 4. New cases of HIV/AIDS diagnosed or moved to North Dakota, 2000-2015



There are 424 people with HIV/AIDS known to be living in North Dakota as of December 31, 2015. Of those, 226 are at the stage of HIV infection and 198 have progressed to an AIDS diagnosis. The group is made up of 298 males and 126 females.

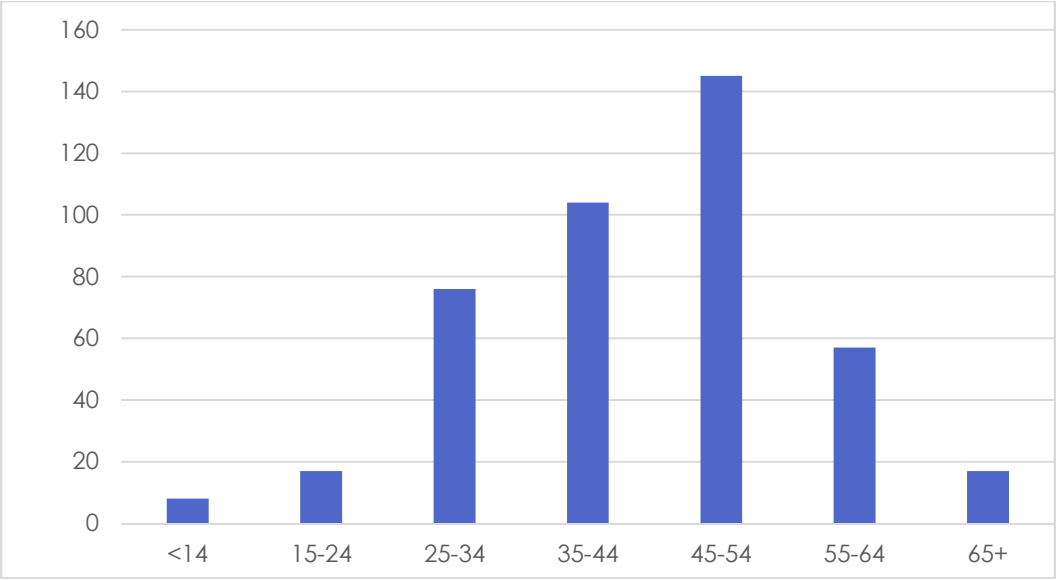
Figure 5. Total cases of HIV/AIDS living in North Dakota separated by disease stage and gender, 2015



Age

One-quarter of those reporting as HIV positive are between the ages of 35 and 44, and one-third are between the ages of 45 and 54. The predominant self-identified risk factor for males at the time of diagnosis is men who have sex with males, at 58 percent of cases. In females, the predominant self-identified risk factor is heterosexual contact, at 83 percent of cases.

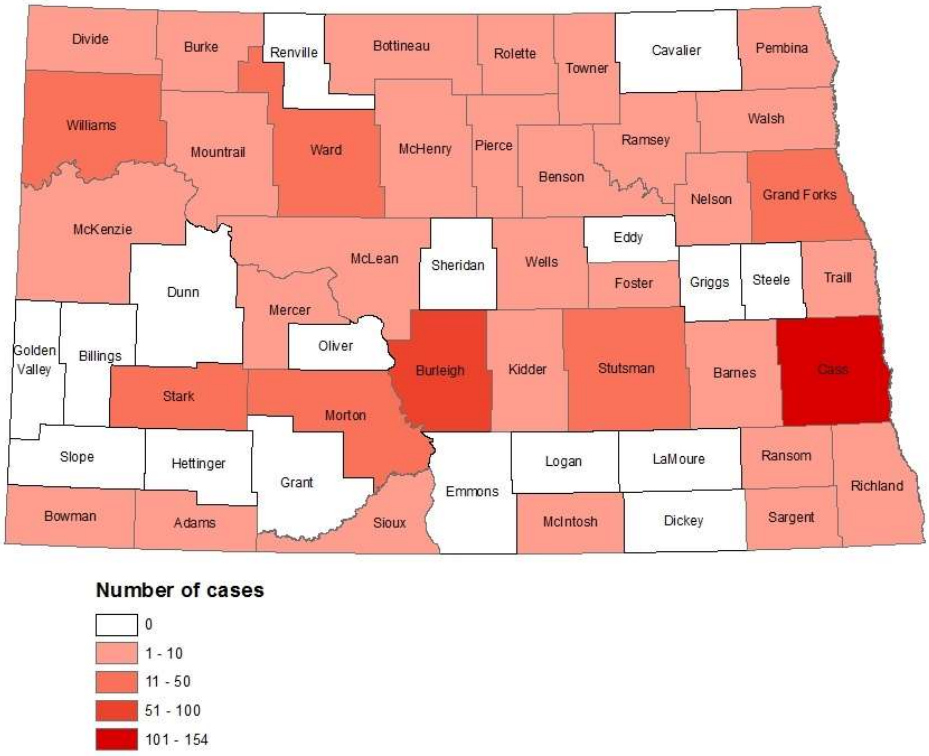
Figure 6. Total cases of HIV/AIDS living in North Dakota separated by age group, 2015



Geography

As of December 31, 2015, there are 36 of 53 counties in which at least one person is living with HIV/AIDS in North Dakota.

Figure 7. Total cases of HIV/AIDS living in North Dakota by county, 2015



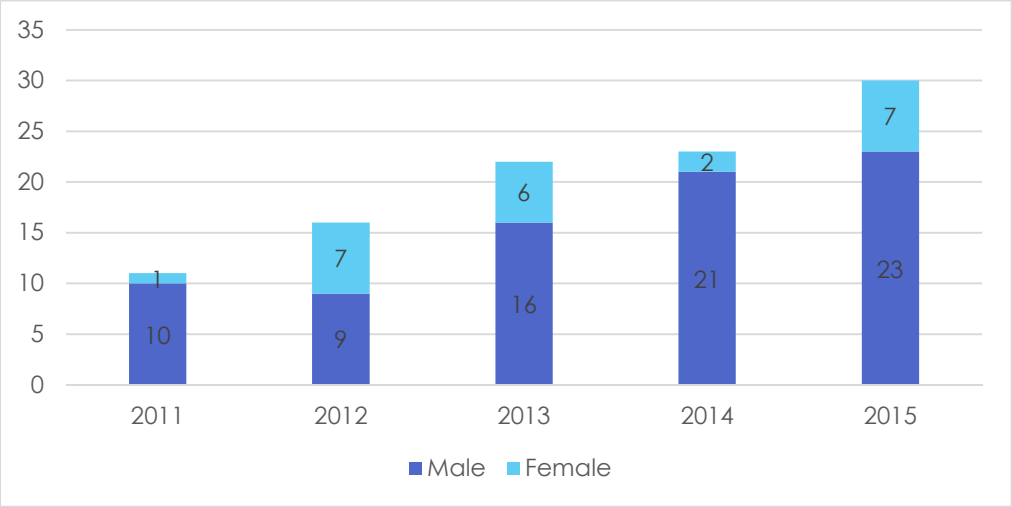
2015 Incidence of HIV/AIDS

Incidence refers to cases newly diagnosed within the state during a given year. Persons that have been diagnosed in another state, then move to North Dakota, are not counted in an incidence report. However, persons that were diagnosed in a foreign country and then move directly to North Dakota are included in the incidence report.

Gender

North Dakota reported 30 new cases of HIV/AIDS in 2015. Twenty-three (77 percent) of the newly diagnosed HIV/AIDS cases were males.

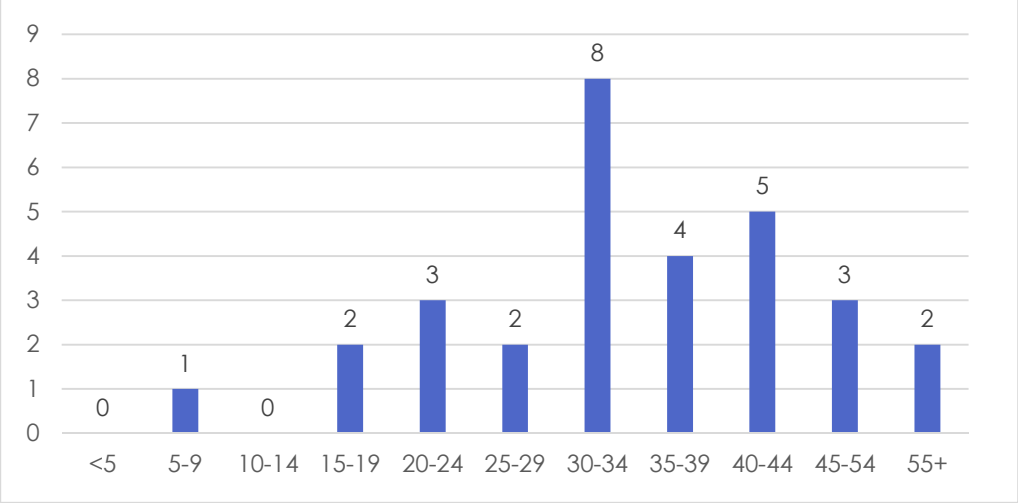
Figure 8. Gender of HIV/AIDS cases diagnosed in North Dakota, 2011-2015



Age

In 2015, the age range of newly diagnosed HIV cases was 7 to 64 years old, with a mean age of 34.

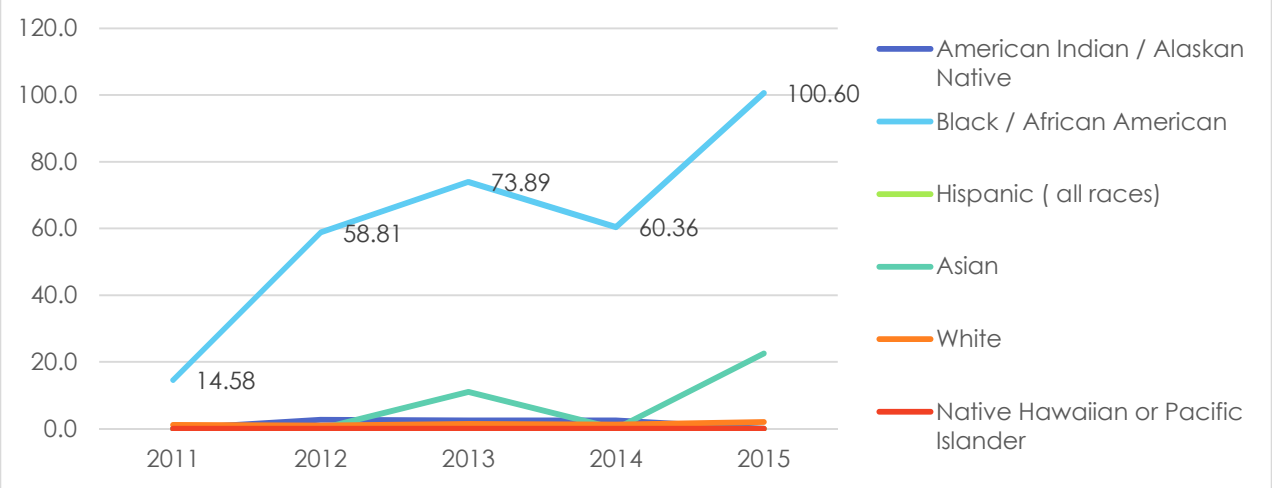
Figure 9. Newly reported HIV/AIDS cases in North Dakota by age group, 2015



Race

In 2015, the race most reported by cases was Black/African American, which accounted for 15 (50 percent) cases. Census estimates from 2014 show that Black/African Americans comprise less than 2 percent of the population in North Dakota, accounting for an incident rate of 100 infections per 100,000 persons. White Americans had the second highest number of reported HIV cases, with 13 reported.

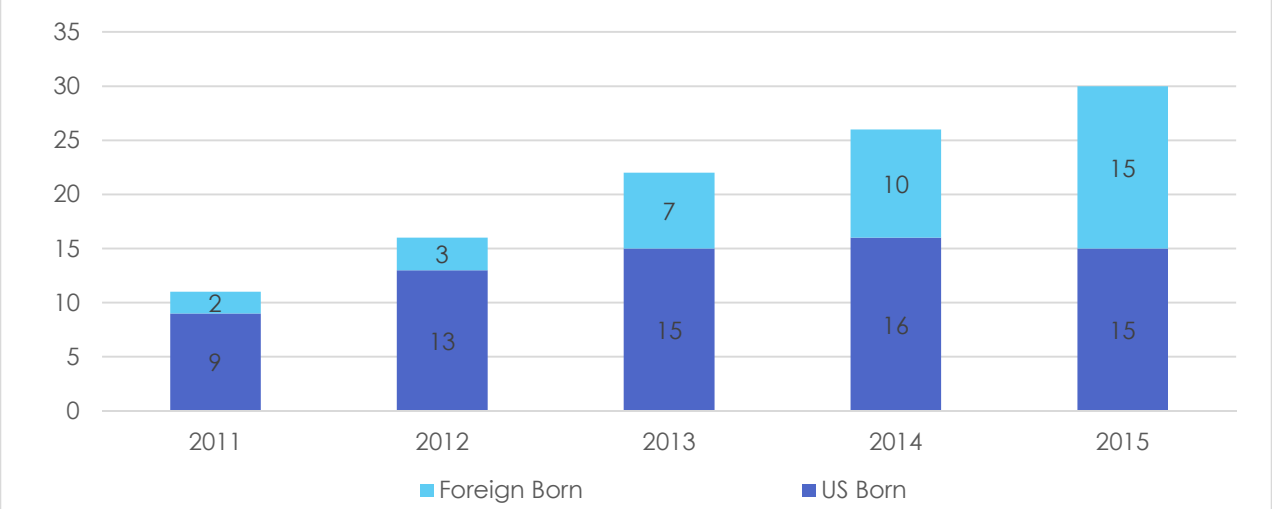
Figure 10. Newly reported HIV/AIDS case rate per 100,000 persons in North Dakota by race group, 2011-2015



Country of Birth

Half of new cases diagnosed in North Dakota were born outside of the U.S. This includes 13 of the 15 newly reported cases among Black/African Americans.

Figure 11. Newly reported HIV/AIDS cases in North Dakota by country of birth, 2011-2015



Geography

The map below shows the seven counties in which at least one new case of HIV was reported in 2015. The maximum number of new cases per county was 12.

Figure 12. Counties in North Dakota with at least one newly reported case of HIV/AIDS in 2015

Risk of Infection

Nationally, HIV is most often reported among men who have sex with men (MSM). North Dakota risk data shows similar patterns between both prevalent cases and incident cases among males from 2011-2015. In female cases diagnosed with HIV in North Dakota, heterosexual contact remained the primary risk factor. No females reported use of injection drugs in the past five years. Below are depictions of the self-identified risk factors among newly diagnosed cases.

Figure 13. Risk factors reported by males newly diagnosed with HIV, 2011-2015

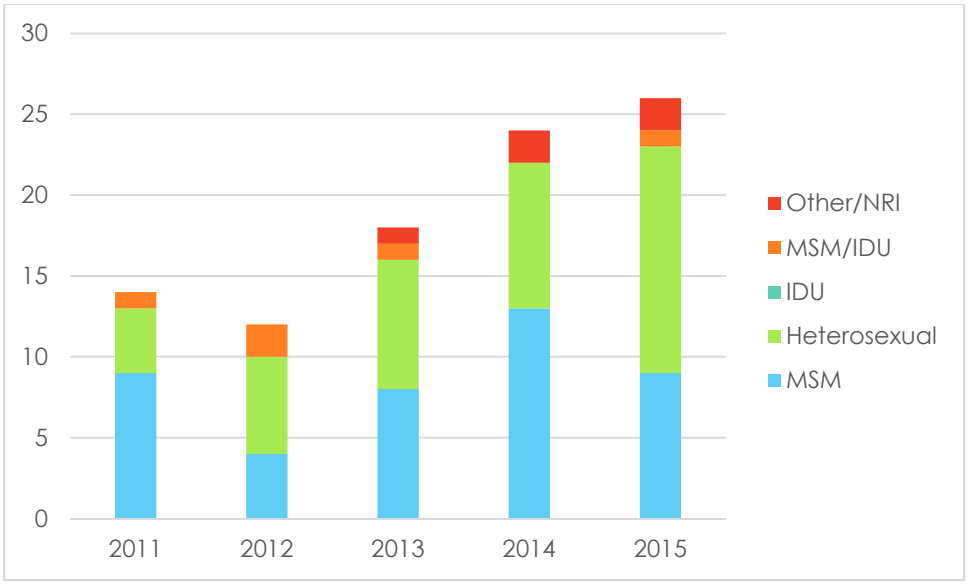


Figure 14. Risk factors reported by females newly diagnosed with HIV, 2011-2015

Factors Affecting the Number of Diagnoses

Although HIV diagnoses are one indication of HIV infection rates, they do not present the complete picture. Many factors may affect when or if a person gets tested for and diagnosed with HIV infection. Many service providers note the following barriers to HIV testing:

- a general lack of knowledge about how HIV is transmitted
- an individual's belief that he/she is not at risk for contracting HIV (perceived risk)
- logistical barriers, such as proximity to testing sites, transportation, and limited hours of operation
- language barriers
- Pervasive stigma associated with HIV

The impact of testing barriers on the state's capacity to identify cases of HIV may be significant. Individuals who are infected and do not know they are infected may not seek testing unless they have the means, the knowledge, or a significant reason (e.g., symptoms) to do so. Considering these possible limitations, studying a broad sample of directed testing efforts is, to some degree, an examination of the potential prevalence of the disease. In 2015, the NDDOH funded 22 free, confidential HIV counseling, testing, and referral (CTR) sites.

Viral Hepatitis

Hepatitis is the general term that means "inflammation of the liver." Many factors can cause hepatitis, including toxins, drugs, viruses, parasites, and other factors. There are several types of viral hepatitis, but hepatitis A, hepatitis B, and hepatitis C are the most common types of viral hepatitis in the U.S. and North Dakota. Hepatitis A (HAV) is transmitted via fecal-oral route primarily by a foodborne pathogen. Hepatitis B and C will be discussed in this document.

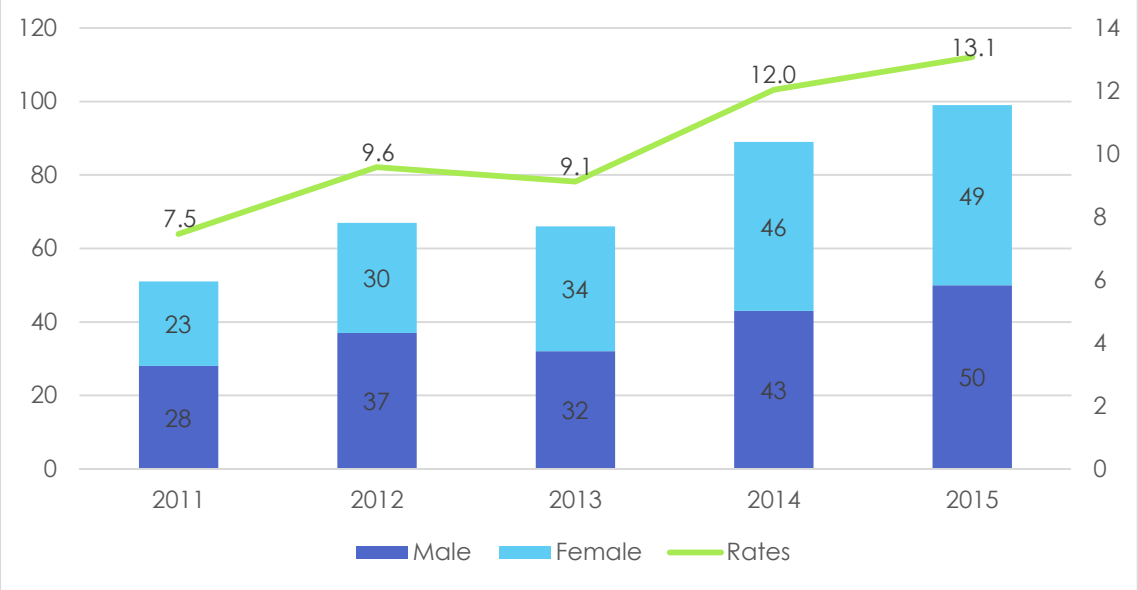
Hepatitis B Virus (HBV)

In 2015, 99 cases of HBV infection were reported in North Dakota. Morbidity is based on reported positive laboratory results meeting the CDC case definition of "Hepatitis B virus infection, chronic." Reported numbers include both confirmed and probable cases.

Gender

Of the 99 HBV-positive people reported in North Dakota, half (49) were female.

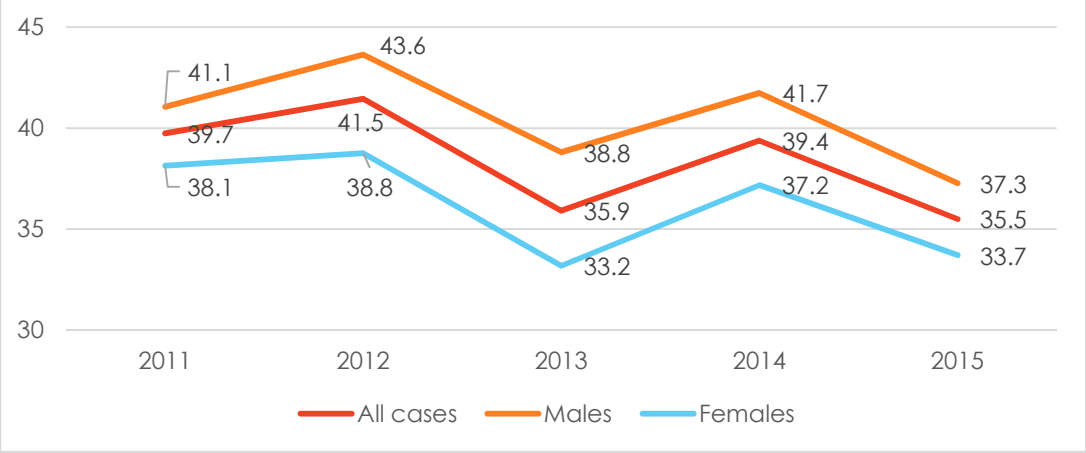
Figure 15. Reported HBV cases by gender and rate per 100,000 persons in North Dakota, 2011-2015



Age

The average age of reported cases in 2015 was 35 years. The range between the youngest and oldest reported cases was 17 to 71 years. The average age of cases has decreased by nearly four years from 2011 to 2015.

Figure 16. Mean age of HBV cases by gender, 2011-2015



Race

Among those reporting race, 61 percent were Black/African American, 10 percent were white and 7 percent were Asian. The majority of cases of HBV occur in persons who are born in countries where HBV is endemic. Since vaccination programs were started in the United States, the number of HBV infections among American born individuals has been drastically reduced.

Figure 17. HBV rate per 100,000 persons by race, 2011-2015

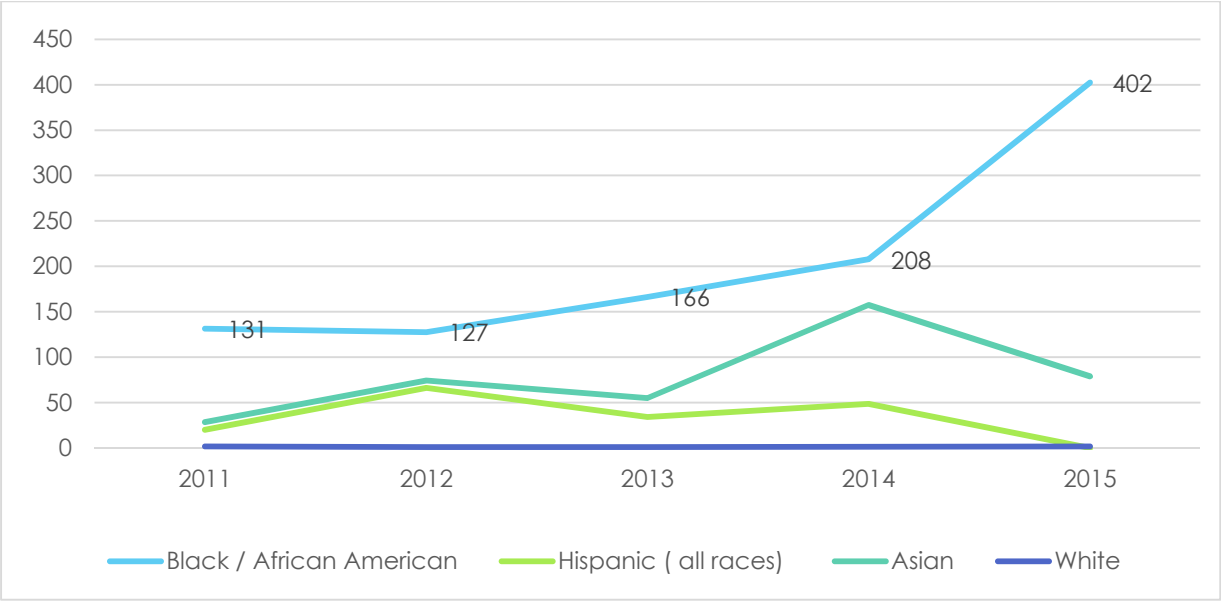
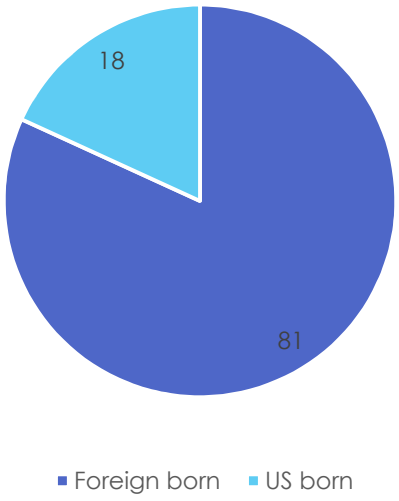


Figure 18. HBV cases by country of birth, 2015



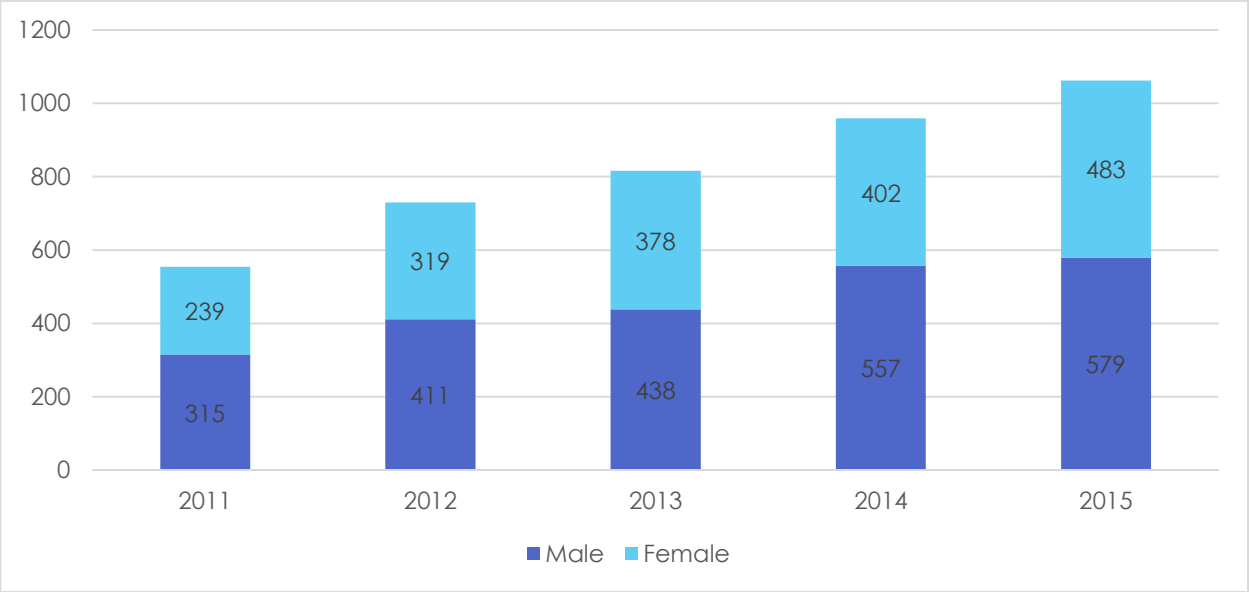
Hepatitis C Virus (HCV)

In 2015, North Dakota received 1,063 reports of people newly identified as having a positive laboratory result that indicates past or present hepatitis C virus (HCV) infection.

Gender

Of the 1,063 HCV-positive reports, 55 percent were male. Male cases increased by 4 percent since 2014 and female cases increased 20 percent in the same time period.

Figure 19. HCV cases by gender, 2011-2015



Age

HCV infections in North Dakota are predominantly an adult infection. Newly diagnosed cases in 2015 were divided roughly in thirds: 25 to 34 year olds, 35 to 54 year olds, and those over 55. Individuals under 25 accounted for less than 5 percent of cases in 2015. The average age of cases in 2015 was 40 years.

Figure 20. HCV cases by age, 2011-2015

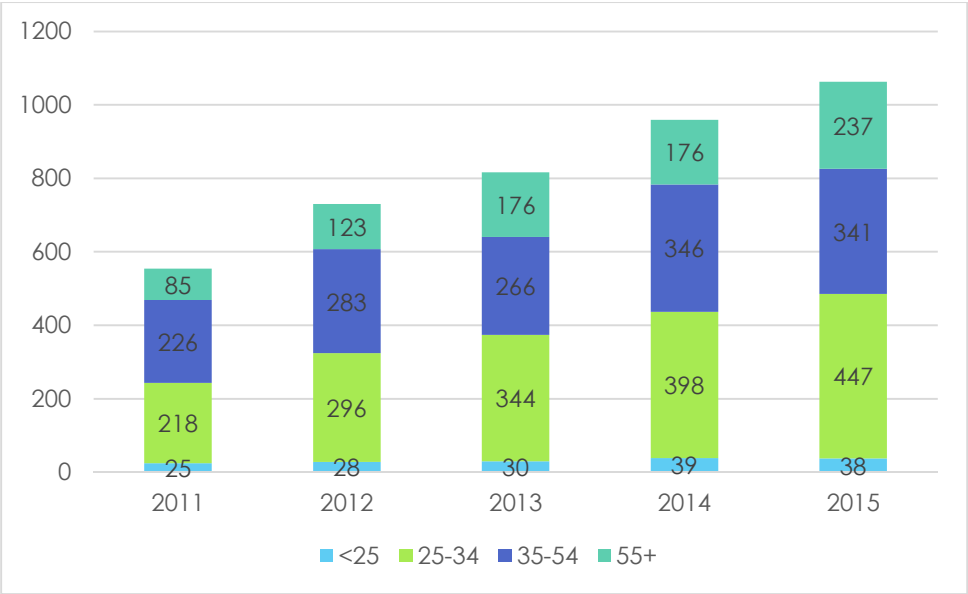
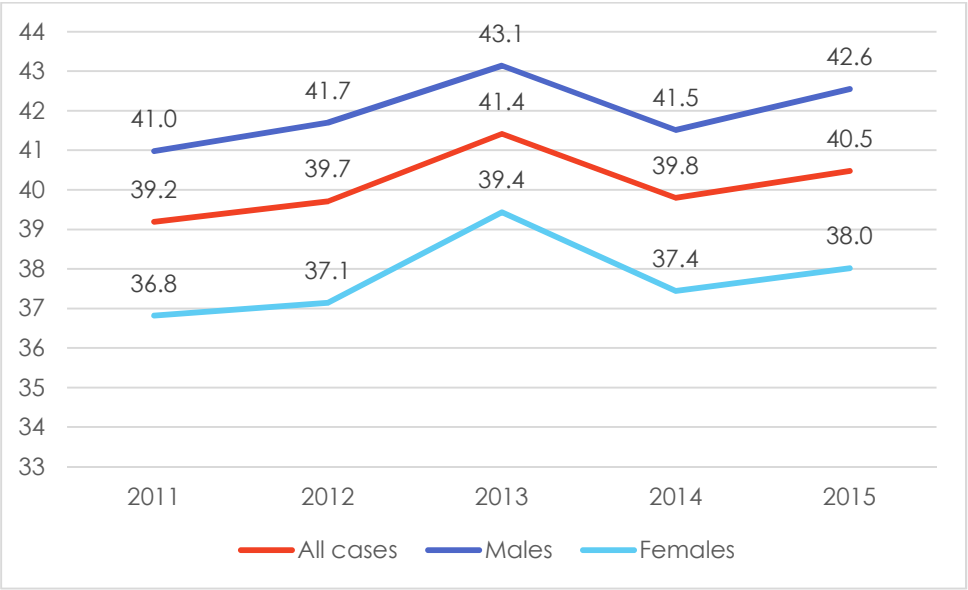


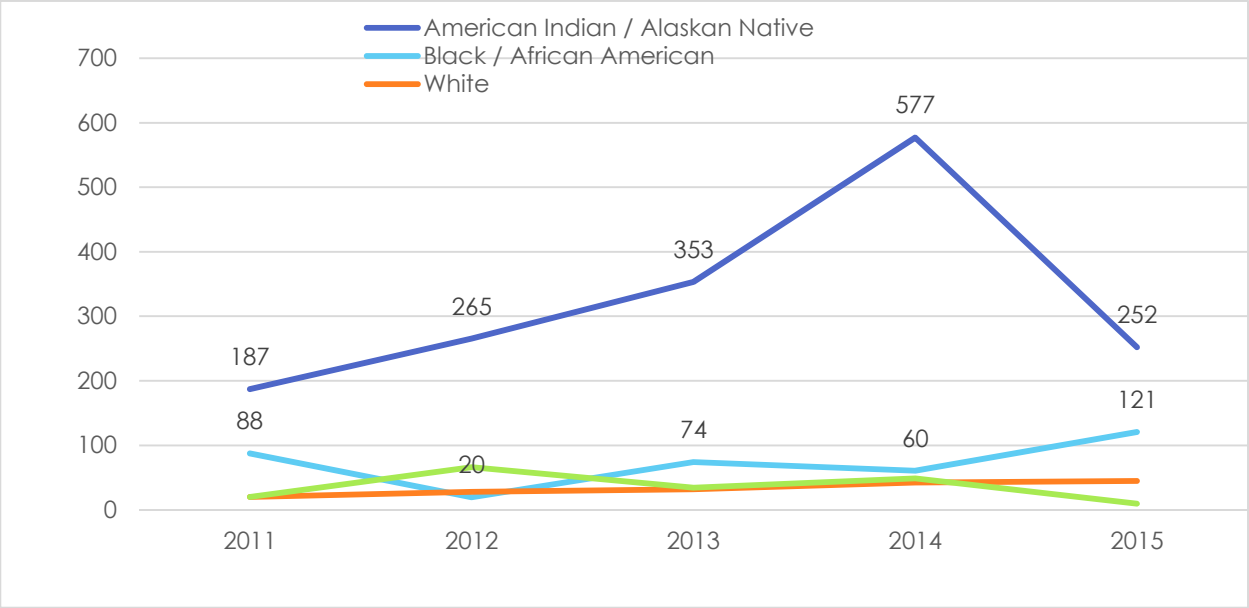
Figure 21. Average age of HCV cases by gender, 2011-2015



Race

Race data is unknown or unavailable for over half of cases since 2011. In 2015, only 421 of 1,063 reported a race. Among those, 27 percent were white and 10 percent were American Indian/Alaskan Native. Rates among American Indian/Alaskan Natives decreased in 2015 to pre-2012 levels. Rates among Black/African American individuals doubled from 60 to 120 cases per 100,000 individuals. Other races did not change significantly from prior years.

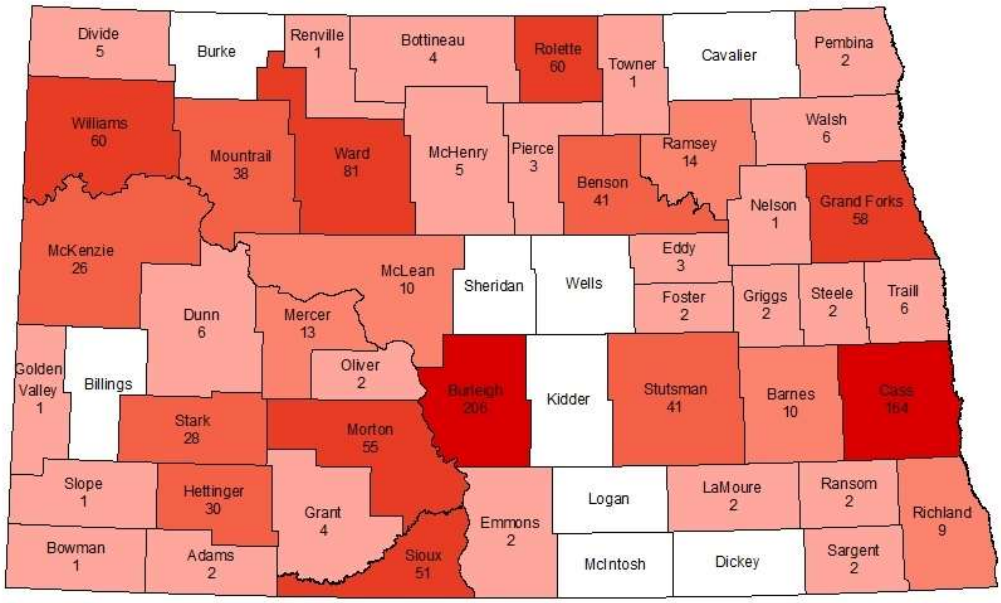
Figure 22. HCV incident rate per 100,000 persons by race, 2011-2015



Geography

Thirty-nine counties reported cases of HCV, similar to previous years. Cases per county ranged from 0 to 206, with a median of 3.

Figure 23. HCV cases by county, 2015



Factors Affecting the Number of Diagnoses

There is no vaccine for Hepatitis C. Nationally, most people become infected with HCV by sharing needles or other equipment to inject drugs. Current and former injection drug users, including those who injected only once many years ago, are at risk. Although increases in injection drug use may be partially responsible for corresponding increases in HCV cases, another factor is changing screening recommendations. In 2012, the CDC augmented recommendations for HCV screening among persons born during 1945-1965, a population with a disproportionately high prevalence of HCV.

Service Delivery in North Dakota

What are the characteristics of those receiving services from HIV/HCV Counseling, Testing and Referral (CTR) Sites?

Section Highlights

In contracted counseling and testing sites (CTR), 4,842 HIV tests were conducted in 2015. Five persons tested positive.

Of the 4,842 tests performed, 2,147 (44.3 percent) were male and 2,679 (55.7 percent) were female.

The majority of patients tested were white; however testing rates were highest among Black/African Americans, where the rate of testing was 3,393.7 tests per 100,000 persons.

The majority of persons tested for HIV reported unprotected sexual activity as their risk factor (91 percent). Fifteen percent identified as MSM, 9 percent as an Injection Drug User (IDU), and 13 percent as having had sex with an IDU.

In 2015, CTR sites tested 2,033 people for Hepatitis C. Of those, 109 persons tested positive.

The majority of patients tested for HCV were white, however testing rates were highest among Black/African Americans, where the rate of testing was 1,066 tests per 100,000 persons.

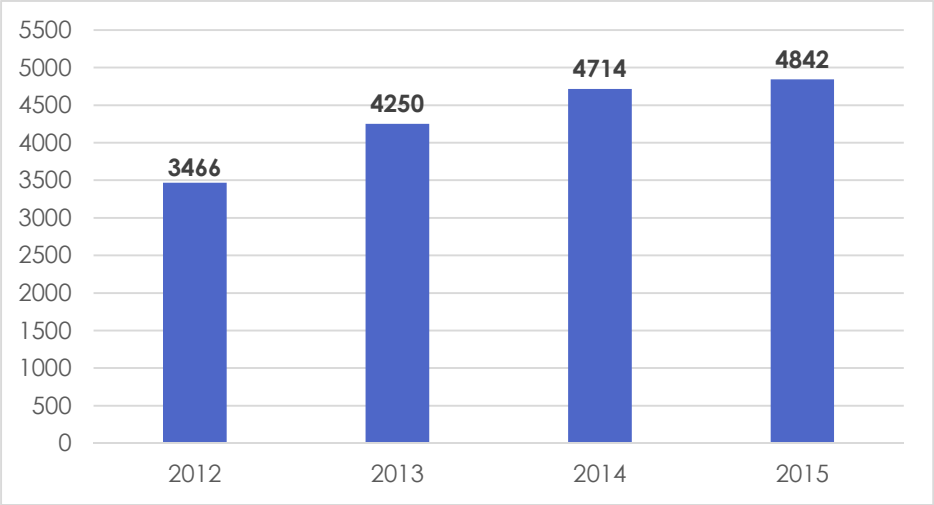
The most often reported risk factor for those tested for HCV was "sex with an IDU" at 27 percent.

HIV & HCV Counseling Testing and Referral Program

HIV/AIDS Counseling, Testing, and Referral Data

NDDoH funds 22 free, confidential HIV/HCV testing and counseling sites and has contracts with all sites to provide rapid testing and subsequent confirmatory testing or referral. Participants complete risk assessments as part of a testing visit or during outreach. In 2015, 4,842 HIV tests were conducted. Five persons tested positive.

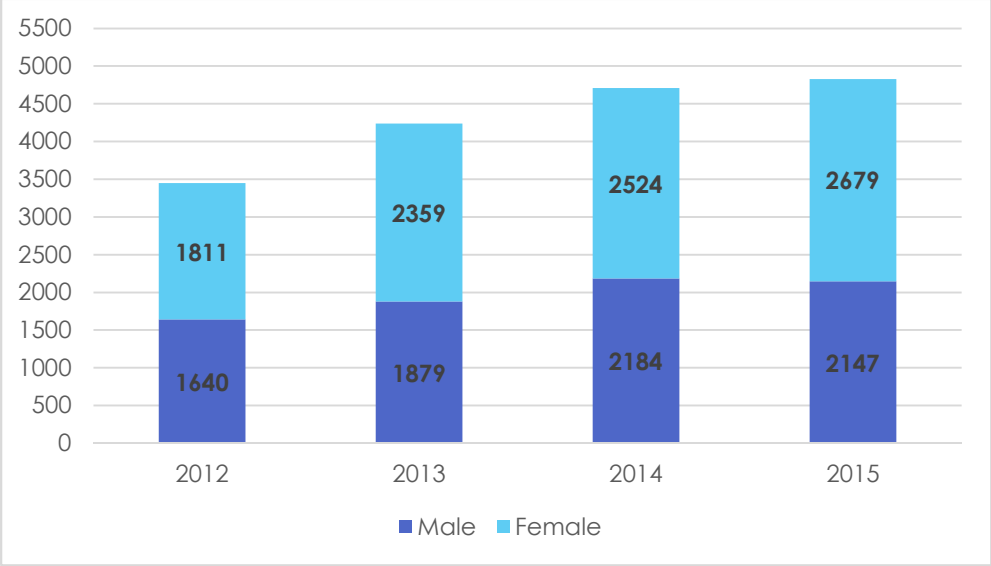
Figure 24. HIV testing conducted at CTR sites, 2012-2015



Gender

Of the 4,842 tests, 2,147 (44.3 percent) were male and 2,679 (55.7 percent) were female. Sixteen tests were reported with unknown or clients refusing to identify their gender. Two of the females tested were transgender male to females. Of the five that tested positive, two were male and three were female.

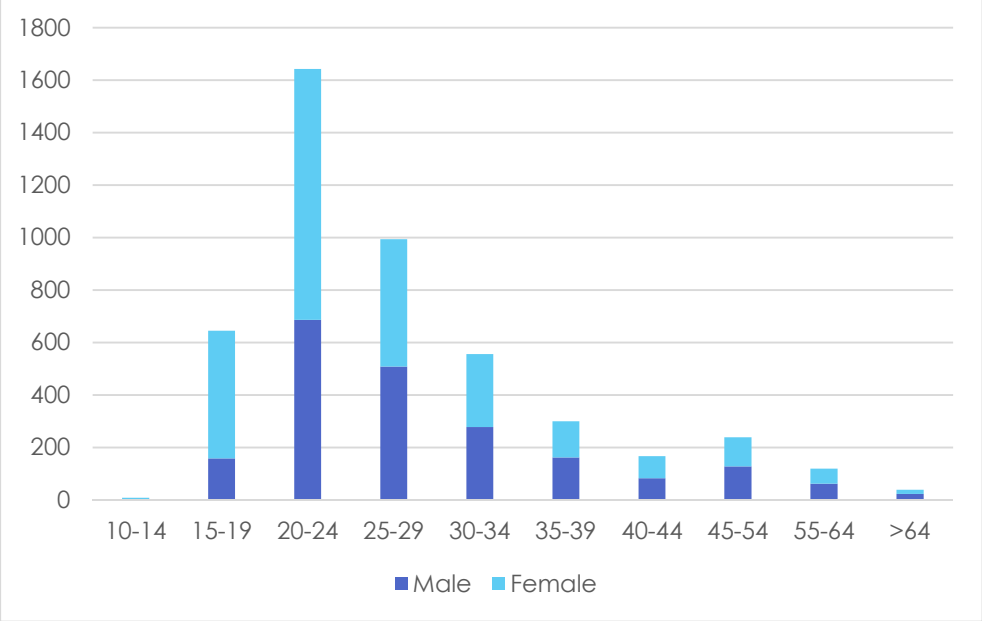
Figure 25. HIV testing conducted at CTR sites by gender, 2012-2015



Age

The majority of people tested were between the ages of 15 and 29. This is consistent with the same age groups with the highest number of incident cases of HIV in North Dakota.

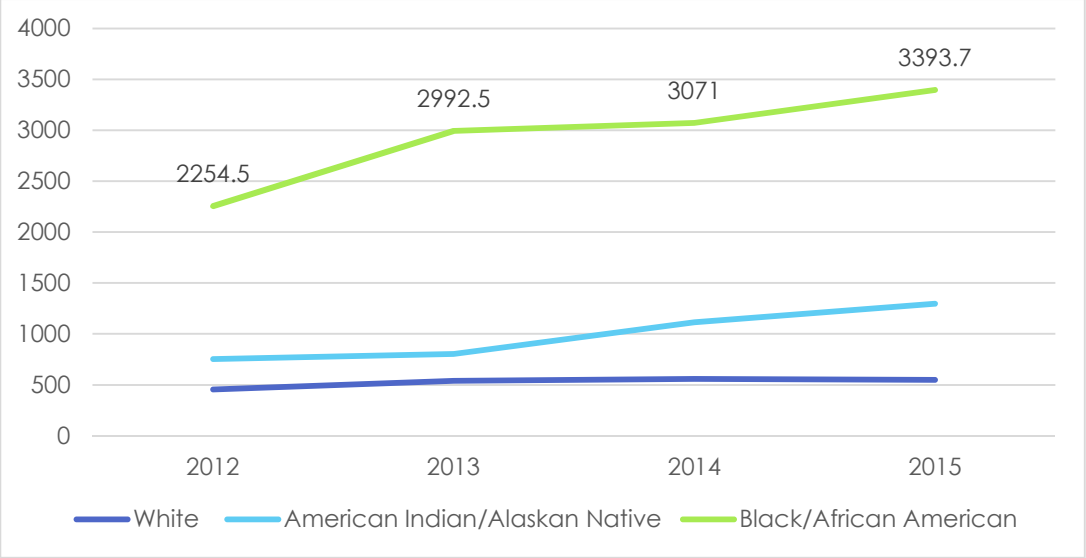
Figure 26. HIV tests at CTR sites by age group and gender, 2015



Race

In 2015, North Dakota CTR sites tested 506 Black/African Americans. There were 3,598 white and 514 American Indian/Alaskan Natives clients. Testing rates and incident rates of HIV are highest among Black/African Americans.

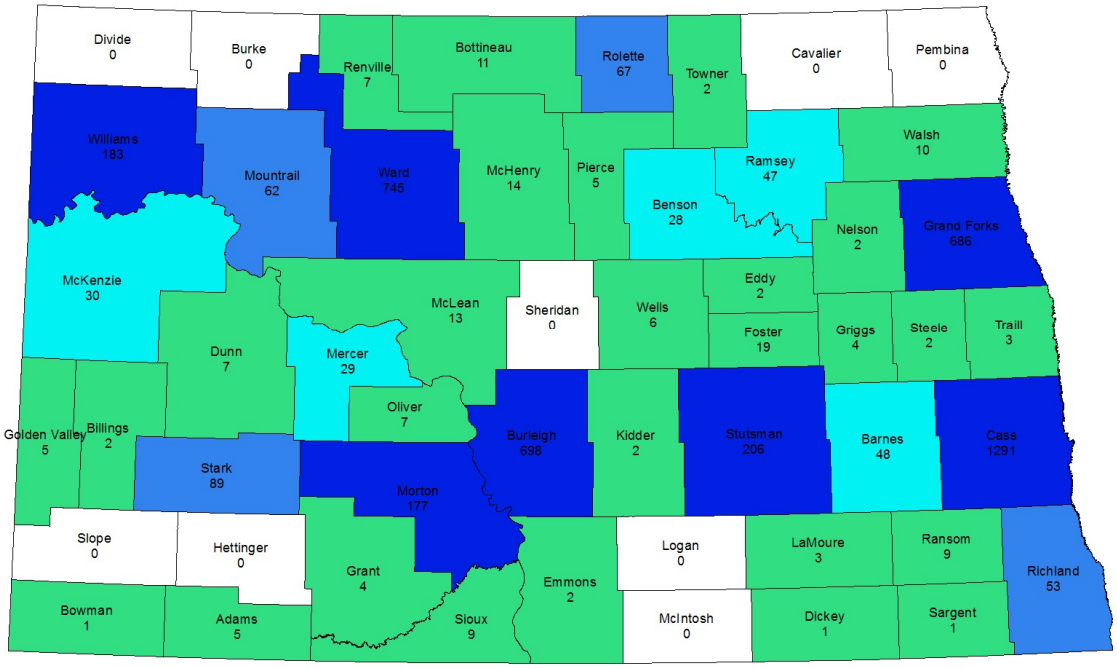
Figure 27. HIV testing at CTR sites rates per 100,000 persons by race, 2012-2015



Geography

At the 22 state-funded CTR sites, residents in 44 of 53 counties were reported to have received an HIV test.

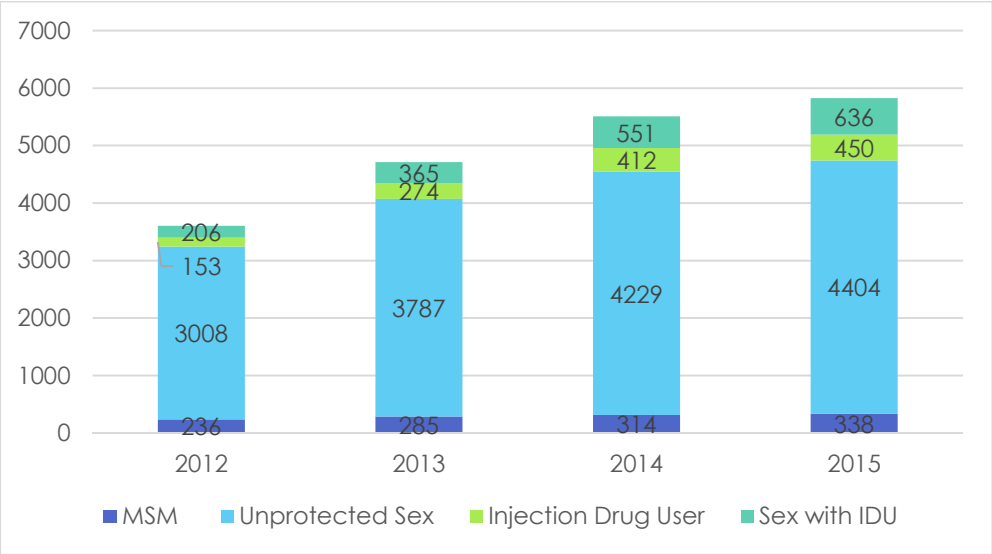
Figure 28. HIV testing at CTR sites by county, 2015



Risk Factors

The risk factors most commonly identified over the past three years continues to be unprotected sex, with 91 percent tested in 2015 reporting this risk factor. Thirteen percent of patients reported having sex with an injection drug user as their reason for seeking testing, followed with 9 percent identifying as IDU. Only 15.7 percent of all males tested identified as MSM.

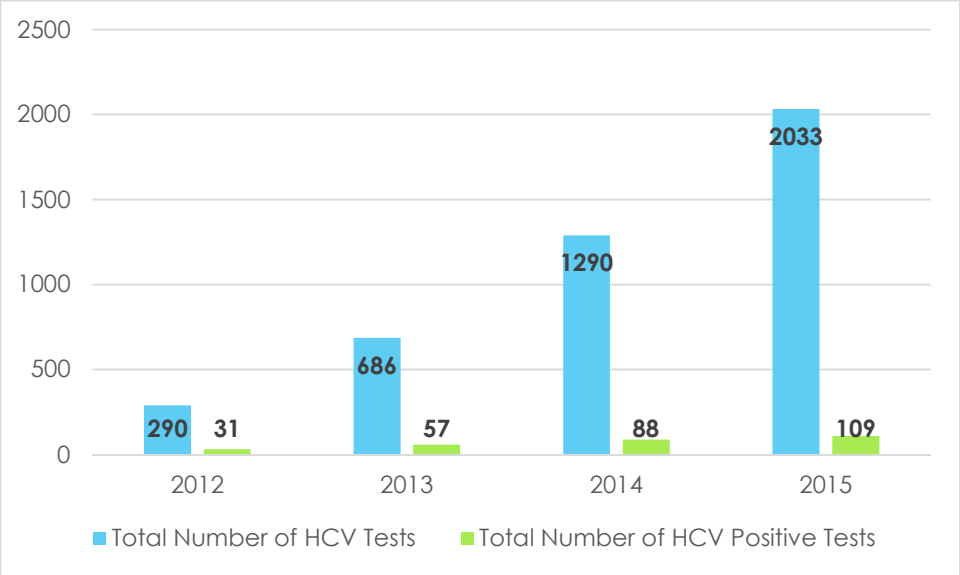
Figure 29. HIV testing at CTR sites by risk factor, 2012-2015



HCV Counseling, Testing and Referral Data

In June of 2013, rapid testing was instituted in CTR sites. This has dramatically increased the number of patients tested. In 2015, 2,033 test were performed, compared to 290 just three years before.

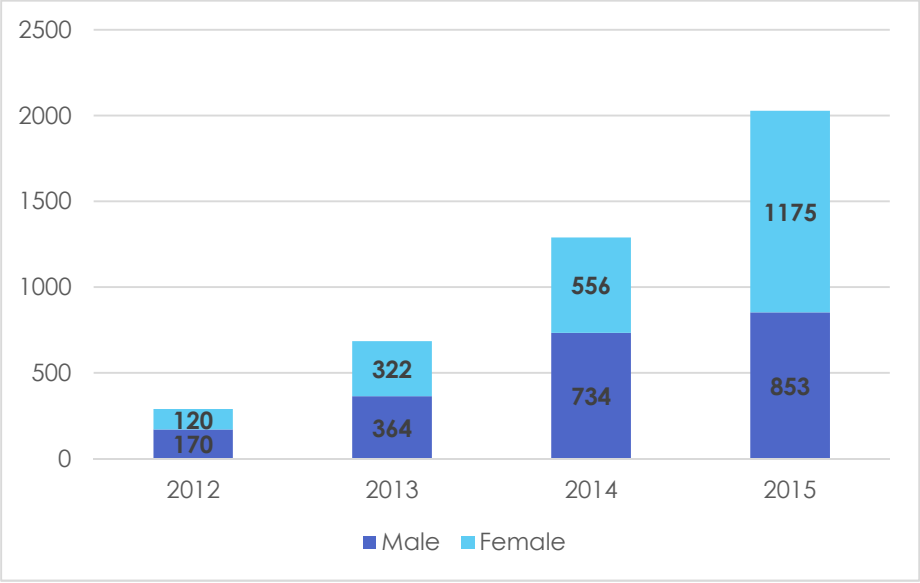
Figure 30. HCV testing at CTR sites, 2012-2015



Gender

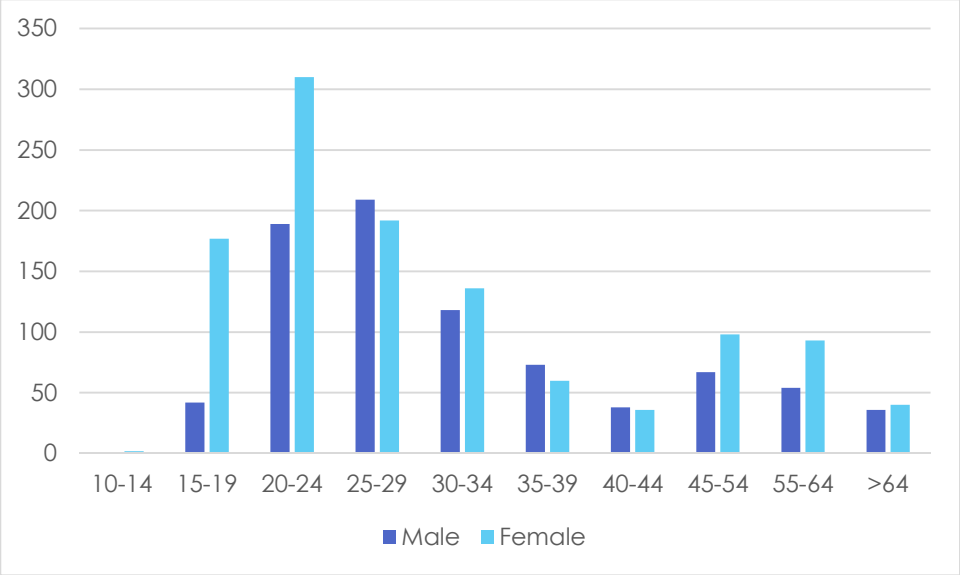
In 2015, 853 (42 percent) males and 1,175 (58 percent) females were tested for HCV at CTR sites. Of those that were positive for hepatitis C, 53 percent were female.

Figure 31. HCV testing at CTR sites by gender, 2012-2015



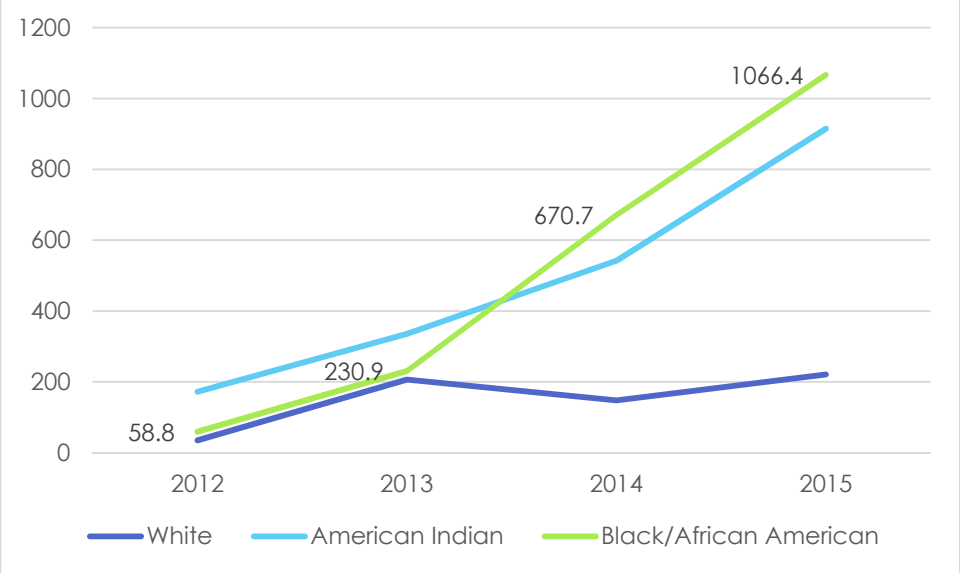
Age

Figure 32. HCV testing at CTR sites by age group and gender, 2015



Race

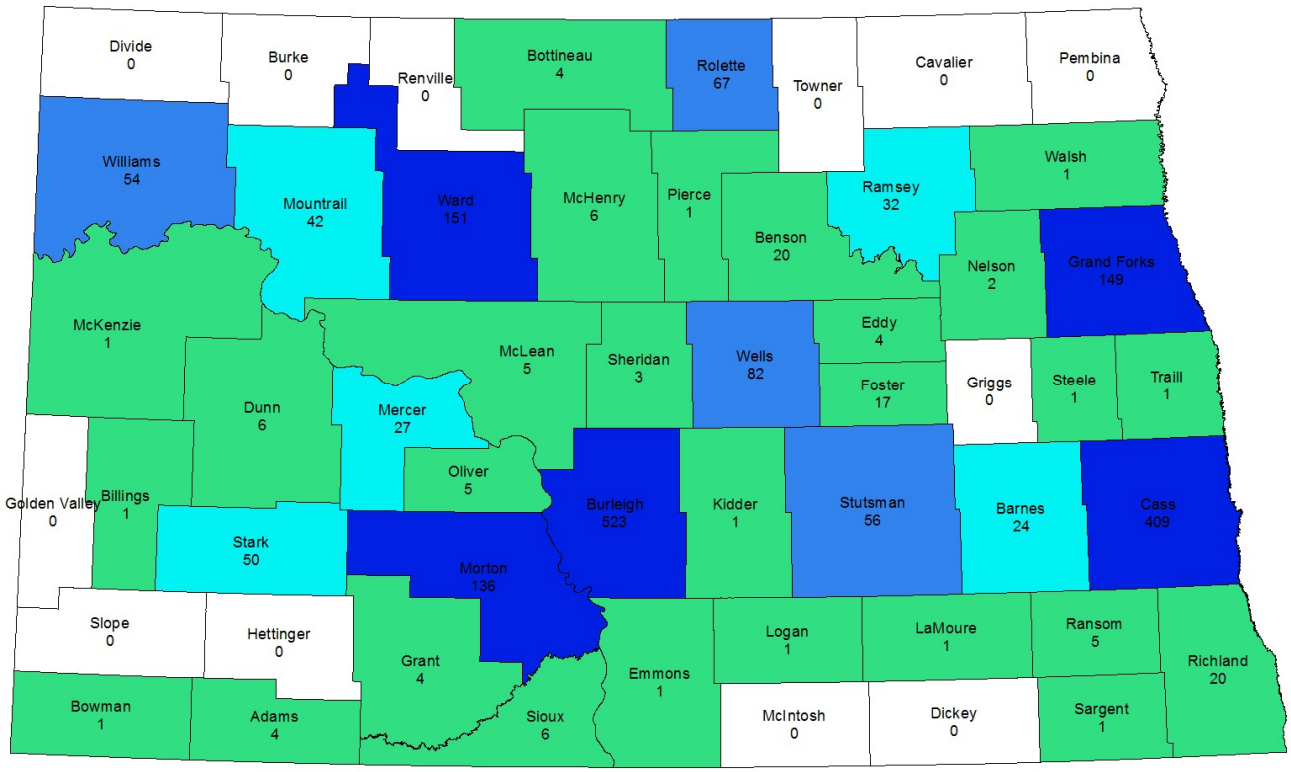
Figure 33. HCV testing at CTR sites rates per 100,000 persons by race, 2015



Geography

Residents of 41 of 53 counties were reported to have received an HCV test.

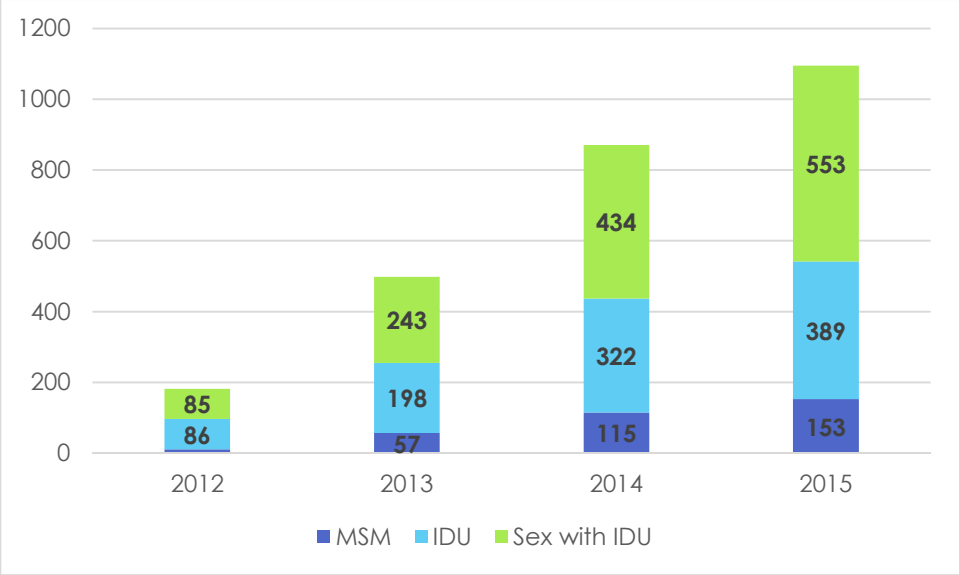
Figure 34. HCV testing at CTR sites by county, 2015



Risk Factors

The risk factors most commonly identified over the past three years continues to be "sex with an injection drug user," with 27 percent of persons tested in 2015 reporting this risk factor. Nineteen percent of patients report being injection drug users, and the least reported risk factor is MSM, at 7.5 percent.

Figure 35. HCV testing at CTR sites by reported risk factor, 2012-2015



What *are the characteristics of those receiving services from Ryan White Part B?*

Section Highlights

North Dakota receives Ryan White Part B funds for the delivery of essential services to individuals and families with HIV disease. In 2015, 11 case managers served 228 clients with Part B services, including medication assistance, medical and non-medical case management, mental health, emergency financial assistance, transportation services, and other support services.

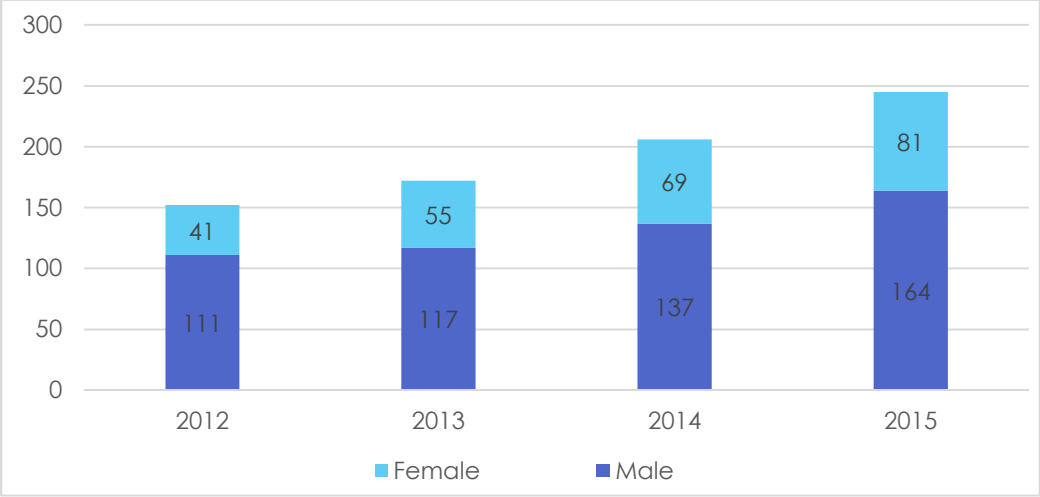
Ryan White Part B

The Ryan White HIV/AIDS Program (RW) assists HIV positive individuals with the cost of medical care, treatment, and support services. As of December 31, 2015, the Ryan White Program served 168 (40 percent) out of 422 persons living with HIV (PLWH) living in North Dakota. The number of Ryan White clients enrolled in the program has increased each year. In 2015, 228 unduplicated clients were enrolled in the program at some point during the year. In 2015, the program raised the eligibility threshold from 300 percent to 400 percent of the federal poverty level (FPL), and this allowed an additional 20 clients (10 percent) to enroll or remain on the program.

Gender

Since 2012, the number of females receiving Ryan White services has nearly doubled. Male enrollment during that time has grown by almost 50 percent. Females now account for one-third of RW clients.

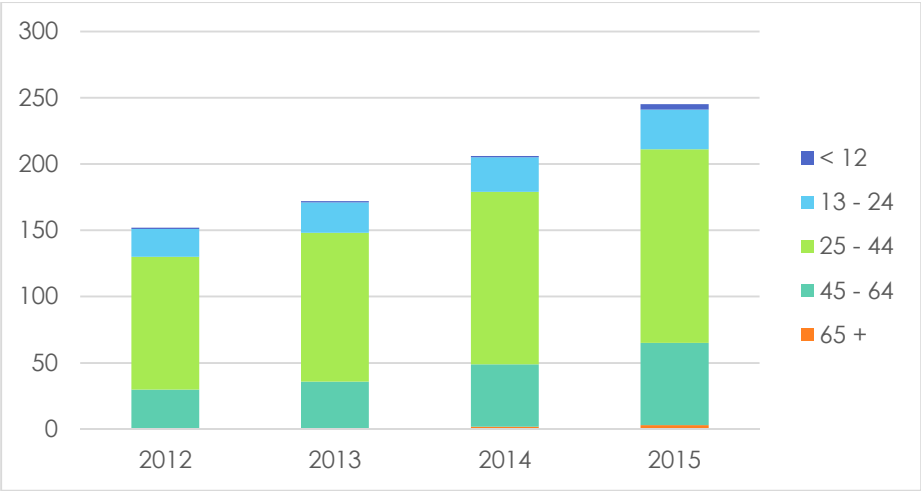
Figure 36. Ryan White clients by gender, 2012-2015



Age

The majority of clients served by the Ryan White program are between the ages of 25 and 44. This has been consistent for several years. Over the past four years, the greatest increase in the number of clients is in the 35 to 39 age group. The average age for RW clients is 44, which is higher than the average age of PLWH living in North Dakota.

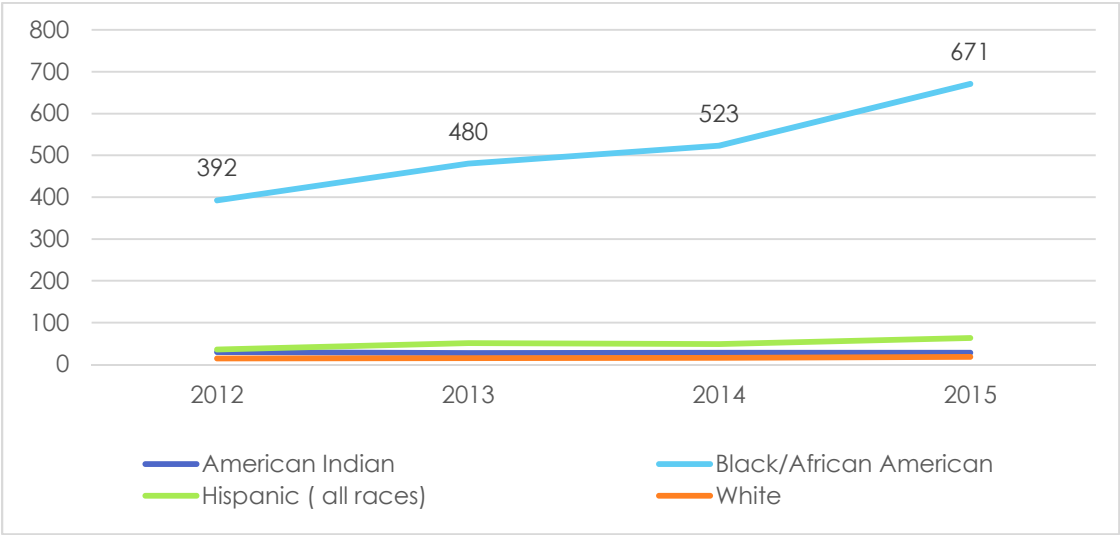
Figure 37. Ryan White clients by age group, 2012-2015



Race

From 2012 to 2015, the number of white RW clients has decreased from 67 to 52 percent, while the number of Black/African American clients has increased from 23 to 40 percent. Surveillance data shows that Black/African American persons are disproportionately affected by HIV. The rate of Black/African American PLWH enrolled in the program is 34 times higher than the rate of white PLWH served.

Figure 38. Ryan White clients rates per 100,000 persons by race, 2012-2015



Geography

Table 2. Ryan White clients served by region and case management site, 2012-2015

Case Management Agency	2012	2013	2014	2015
Western Region	**6**	**9**	**12**	**17**
SWDHU - Dickinson	3	6	8	10
UMDHU - Williston	2	2	3	6
UMDHU - Stanley	1	1	1	1
Southcentral Region	**31**	**40**	**47**	**56**
Bismarck Burleigh Public Health	19	27	34	43
Central Valley Health Unit	7	7	7	7
Custer Health	5	6	6	6
Northcentral Region	**14**	**21**	**24**	**28**
First District Health Unit	12	18	20	24
Lake Region District Health	2	3	4	4
Eastern Region	**90**	**106**	**114**	**127**
Fargo Cass Public Health	67	80	87	99
Grand Forks Public Health	20	23	24	25
Richland County Health	2	2	2	2
Southeastern ND Community Action*	1	1	1	1
Total Number of Clients Enrolled	**141**	**176**	**197**	**228**

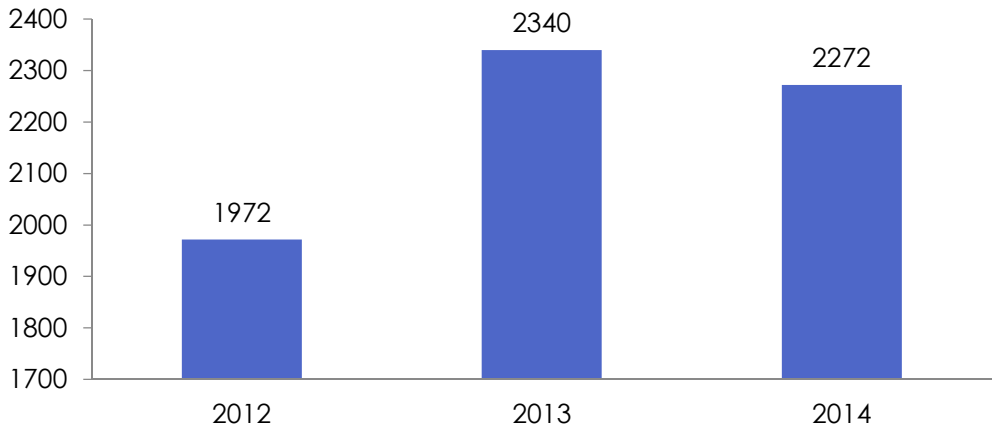
*SENDCAA provides comprehensive case management to one client and provides housing case management to multiple clients; however, those clients are fully managed at Fargo Cass Public Health Unit (FCPH), and are counted under FCPH.

ADAP

The AIDS Drug Assistance Program (ADAP) provides medication assistance to uninsured and underinsured RW clients. Medications on the ADAP formulary are reimbursed to contracted pharmacies at 100 percent up to the Medicaid reimbursed rate. Pharmacies use Medicaid Managed Information System for claims submission in real time.

The number and scripts dispensed, and overall total cost, have decreased significantly since the implementation of Medicaid Expansion and Qualified Health Coverage through the Federally Facilitated Marketplace. Figure 64 show the number of fills per fiscal year (April 1 through March 31). There was a decrease in number of fills in 2014 compared to 2013, and the annual cost per client served has decreased from $31,372.80 in 2012 to $25,262.74.

Figure 39. ADAP medication fills by year, 2012-2014



HIV Care Continuum

The HIV care continuum is a model that outlines the steps of HIV medical care from initial diagnosis to achieving the goal of viral suppression, and indicates the proportion of individuals living with HIV who are engaged at each stage. The continuum has the following stages: diagnosis of HIV infection, linkage to care, retention in care, receipt of antiretroviral therapy, and achievement of viral suppression. As various obstacles contribute to poor engagement in HIV care and limit the effectiveness of efforts to improve health outcomes, the care continuum is used to better identify gaps in HIV services and develop strategies to improve engagement in care and outcomes for PLWH.

The CDC currently uses two different continuums. The HIV prevalence-based continuum shows steps of the continuum as a percentage of the total number, or the prevalence, of PLWH. The diagnosis-based continuum shows steps as a percentage of the number of PLWH who were only diagnosed. For more comprehensive and inclusive data, North Dakota, as a low-incidence state, has developed the prevalence-based continuum.

The steps of the continuum are for PLWH living in North Dakota as of December 31, 2015. The measurement year is the calendar year 2015. The steps are as follows:

- HIV-Diagnosed: number of prevalent HIV cases; prevalent cases include the number of newly diagnosed HIV cases in North Dakota, as well as previously diagnosed HIV cases who moved to the state, and were living in North Dakota as of December 31, 2015
- Linked to Care: the number of PLWH in the calendar year 2015 that had one or more viral load or CD4 test after their diagnosis date
- Retained in Care: the number of PLWH with one or more viral load or CD4 labs in the measurement year
- Antiretroviral Use: number of PLWH who have a documented antiretroviral therapy (ART) prescription in the Maven surveillance system
- Viral Load Suppression: number of PLWH whose most recent HIV viral load within the measurement year was less than 200 copies /mL.

Limitations: HIV is a reportable condition in North Dakota, and all viral load and CD4 lab tests are electronically reported to the NDDoH. However, NDDoH does not perform medical chart reviews on PLWH to determine all HIV related medical visits or antiretroviral use. This contributes to possible underreporting of the number of individuals linked and retained in care, and to underreporting of individuals receiving ART. The number of individuals prescribed ART is determined by using RW ADAP reimbursed claims data. Therefore, only individuals who are on RW and whose medications are reimbursed through ADAP, are reported as receiving ART. This excludes individuals not on RW, as well as those who are on RW but whose medications are reimbursed through primary coverage (i.e., private insurance, Medicaid or Medicare).

As of December 31, 2015, there were 424 PLWH in North Dakota. Of those, 168 (40 percent) were enrolled in RW. Eighty-one percent of all PLWH are linked to care and reported at least one medical visit since their diagnosis. Seventy four percent were retained in care by having a

medical visit in 2015. Sixty-four percent were receiving ART, and 59 percent were virally suppressed. Compared to the national rates (Figure 41), North Dakota has significantly higher rates along each stage of the continuum. The national suppression rate is 30 percent, whereas the overall suppression rate for North Dakota is 59 percent.

Figure 40. Number of Persons Living with HIV in North Dakota as of December 31, 2015

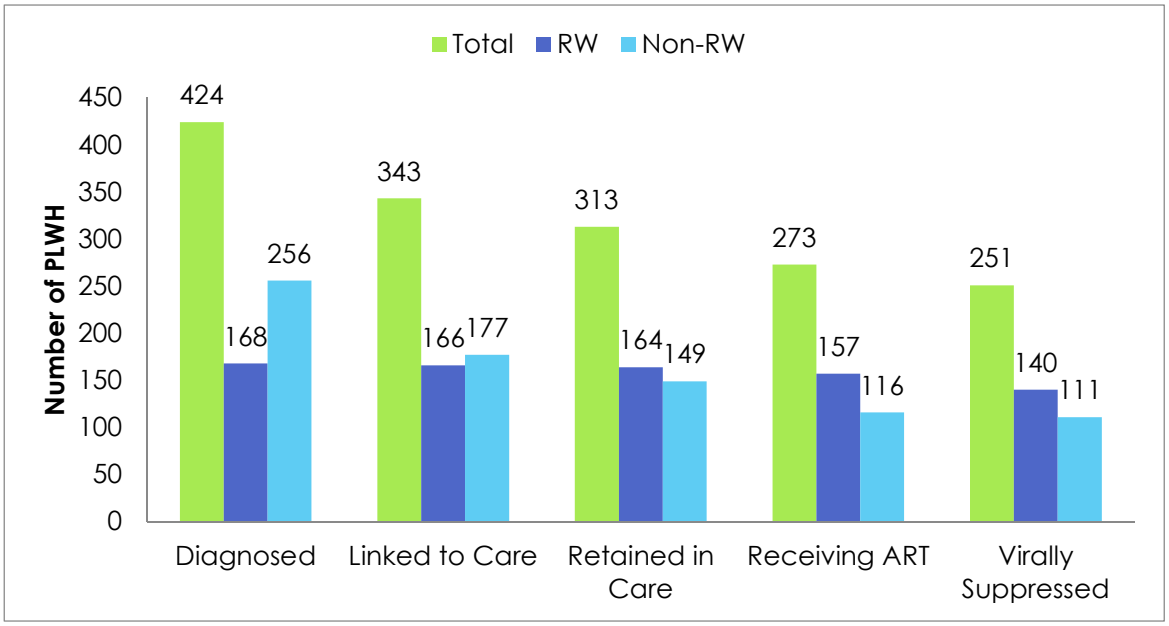
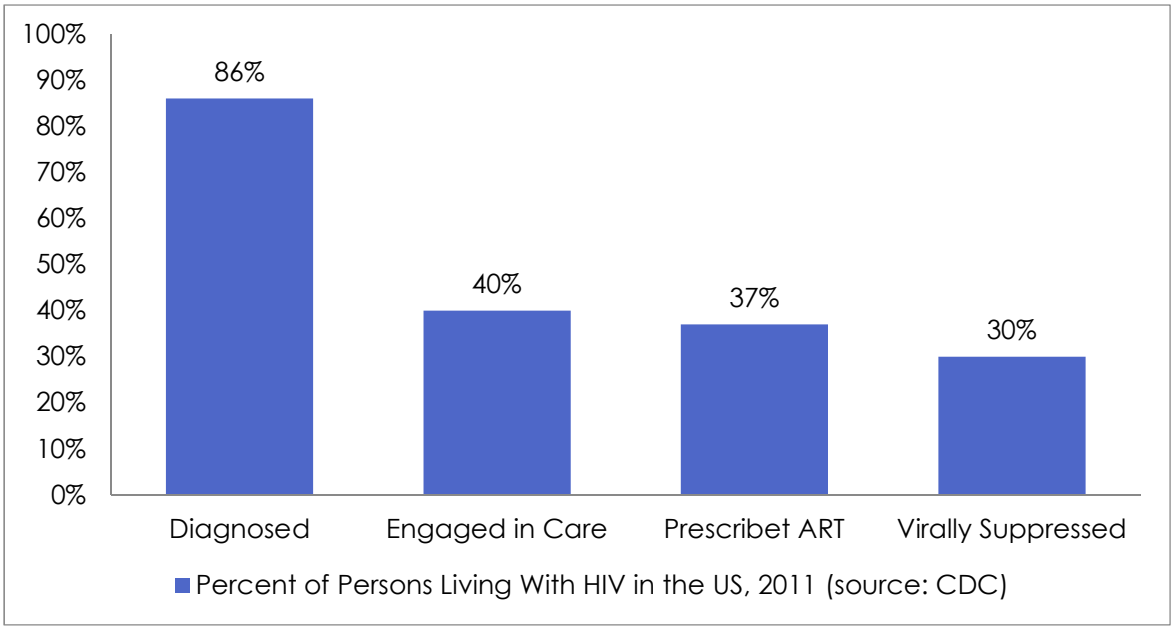


Figure 41. Percent of Persons Living with HIV in the US, 2011



Source: CDC (Bradley H, et al. MMWR 2014; 63:1113-7)

There is a significant disparity between the PLWH not enrolled in RW versus those enrolled (Figure 3). Non-RW PLWH, compared to RW clients, were almost half as likely to be engaged in care along each step of the continuum, with half the rate of viral suppression, and thus much poorer medical and health outcomes. Sixty-nine percent of non-RW PLWH are linked to care, and only 43 percent are virally suppressed, compared to 98 percent of RW clients who are retained in care and 83 percent who are virally suppressed. Looking closely at the unsuppressed RW clients, the number seems to be higher than it truly, likely because in many instances, clinicians will stop ordering viral loads and only order CD4 counts to monitor the immune system health on those clients that have been virally suppressed for a period of time and are adherent to their treatment.

The greatest obstacle for PLWH seems to be the initial step of getting linked to care, where only 69 percent have had a medical visit within 12 months of diagnosis. Once the clients were linked to a provider, 84 percent continued to see their provider regularly, and 73 percent of those retained in care were virally suppressed.

Reaching viral load suppression is important for several reasons. Viral suppression ensures that the health of the person is maintained or restored. It also minimizes or eliminates short or long-term damage caused by the virus, and lowers the risk of HIV transmission since there is less amount of virus the blood and body fluids.

Figure 42. Percent of Persons Living with HIV in North Dakota as of December 31, 2015

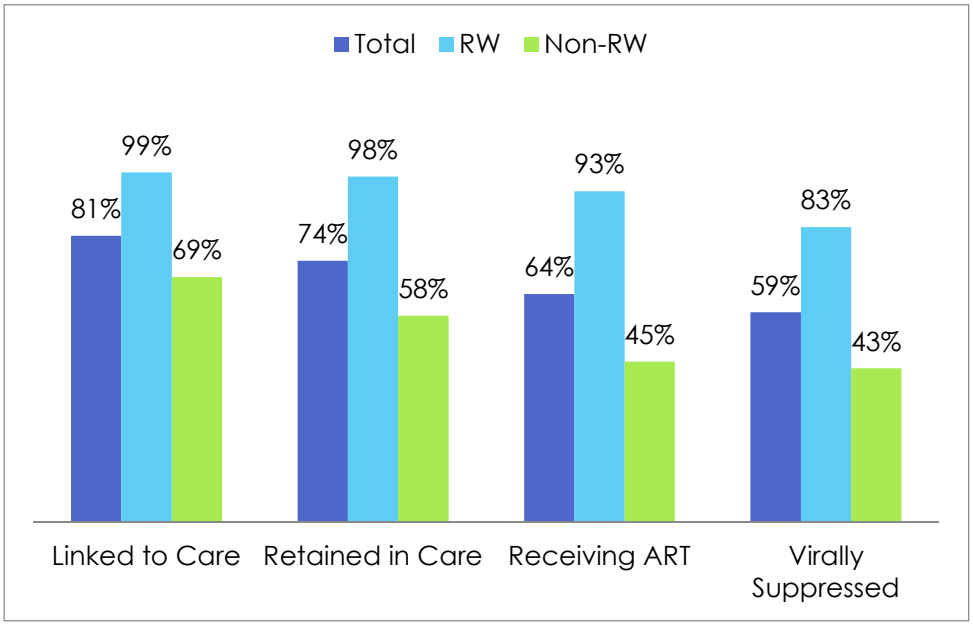


Figure 43. Number of Persons Living with HIV in North Dakota by Race

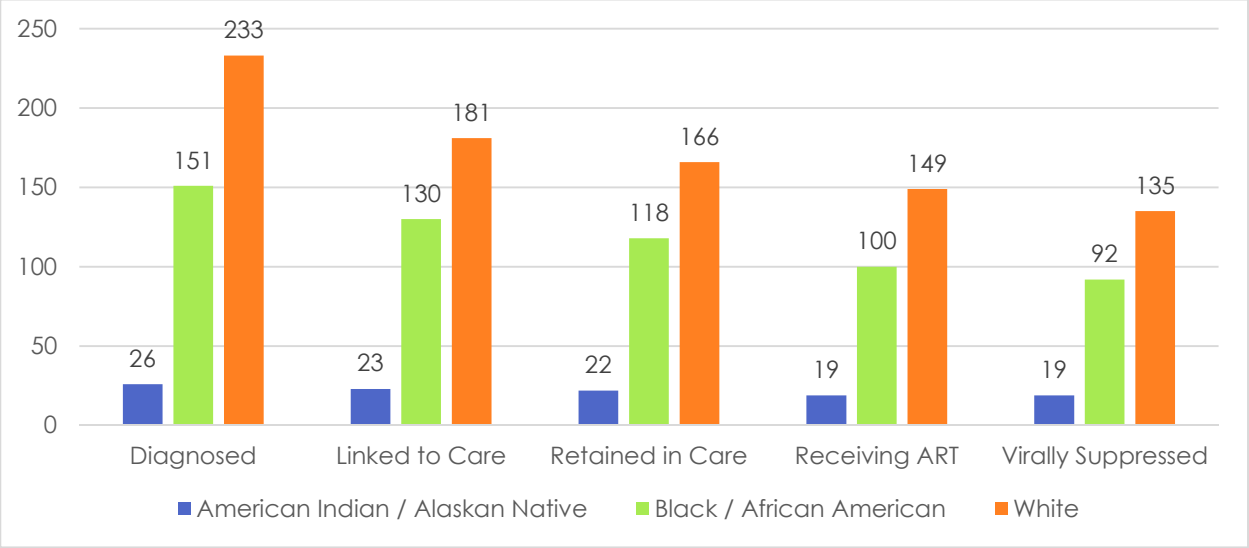
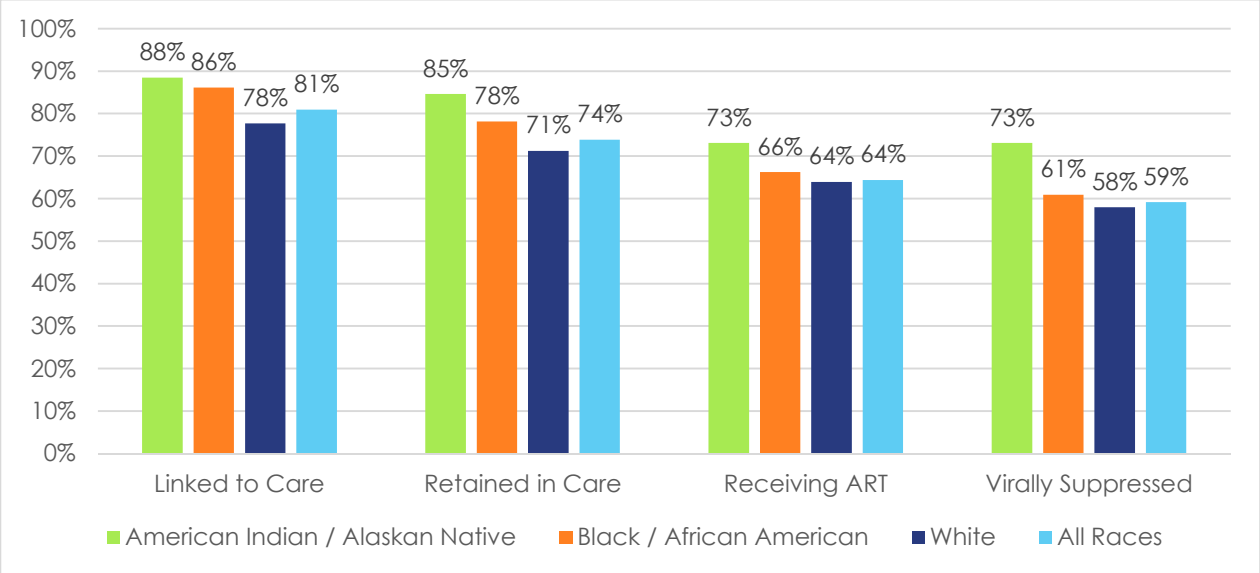


Figure 45. Percent of Persons Living with HIV in North Dakota by Race



There does not seem to be a racial disparity among PLWH living in North Dakota for access and retention in care. Black or African American PLWH have viral suppression rate of 61 percent, which is slightly higher than the viral suppression for White PLWH. Black/African American women have a have a higher viral suppression percent (67 percent) compared to Black/AA men (55percent). American Indians PLWHs have an even higher rate of viral suppression of 73 percent.

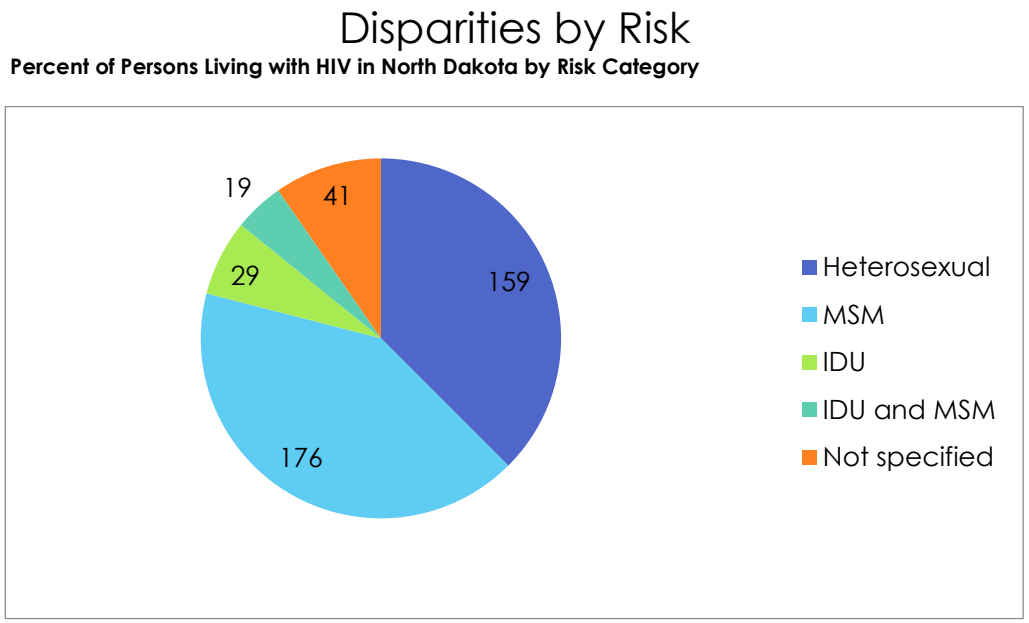


Figure 46. Percent of Persons Living with HIV in North Dakota by Risk Category

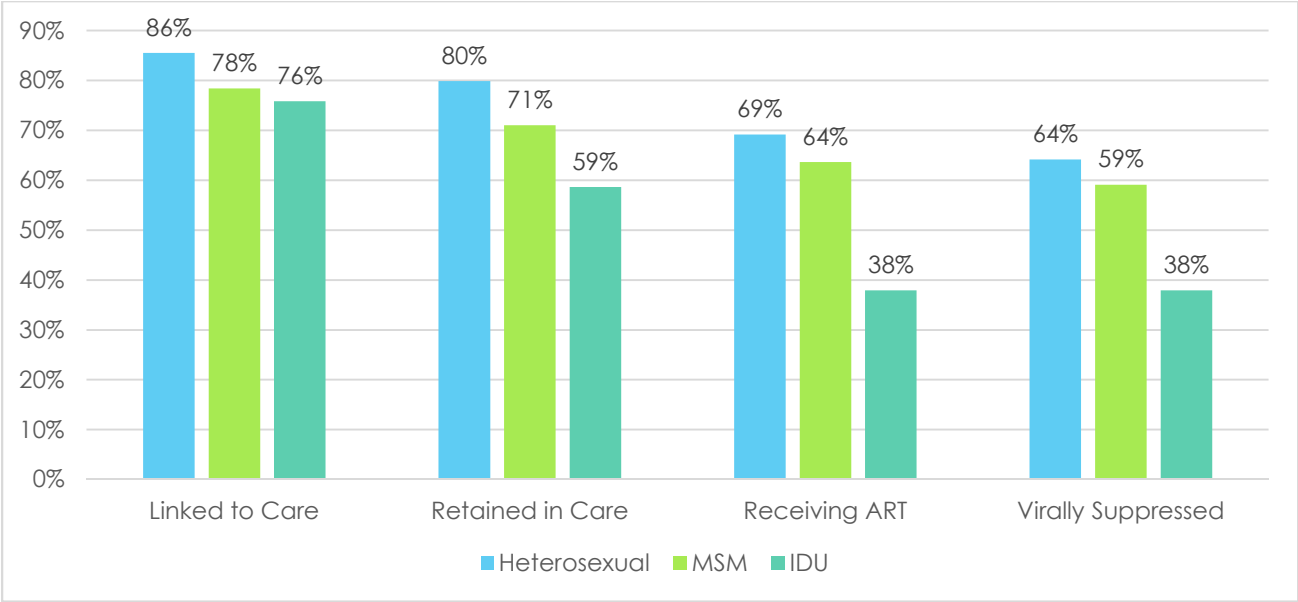


Figure 47. HIV Care Continuum by Risk Category

The majority (42 percent) of PLWH living in North Dakota as of December 31, 2015, were men who have sex with men (MSM). Thirty seven percent are heterosexual, and 10 percent did not have a specified risk category. Seven percent reported IDU as a risk factor, and 4 percent reported both IDU and MSM risk factors.

Looking at the care continua for each risk category, MSM and IDU are more likely to be out of care than a heterosexual PLWH. Seventy-six percent of IDU, and 78 percent of MSM are linked to care, compared to 86 percent of heterosexual PLWH. The highest disparity is seen with IDU PLWHs, where only 38 percent of individuals are virally suppressed, compared to 64 percent of heterosexual and 59 percent of MSM PLWHs.

The HIV Care Continuum provides a model to monitor progress toward the objectives outlined in the National HIV/AIDS Strategy (NHAS). The model will also be used by the Community Planning Group for HIV and Viral Hepatitis Prevention and Care (CPG) for planning and prioritizing goals and resources to address the needs and disparities of PLWH in North Dakota. The CPG will develop appropriate interventions to address the racial and socio-economic disparities, as well as determine necessary re-engagement activities to improve outcomes at each state of the care continuum.

The existing services, such as partner services, additional testing for comorbidities, educational opportunities regarding care and treatment, and prevention with positives activities will be reevaluated to assess their effectiveness and potential areas for improvement.

Financial and Human Resources Inventory

The table below describes the HIV resources available in North Dakota for HIV and Viral Hepatitis Prevention and Care.

Table 3. HIV and Viral Hepatitis Funding Sources, 2015.

Funding Source	Funding Amount	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps(s) Impacted
HIV Funding				
CDC HIV Prevention	$711,602	North Dakota Department of Health	HIV Testing, Prevention for Positives, Condom Distribution, Jurisdictional Planning	HIV-Diagnosed, Linkage to Care, Retained in Care
CDC HIV Surveillance	$122,097	North Dakota Department of Health	Epidemiology Support, Partner Services.	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Ryan White Part B	$729,683	North Dakota Department of Health	Core Medical Services, Supportive Services, ADAP	HIV-Diagnosed, Linkage to Care, Retained in Care, Antiretroviral Use, Viral Load Suppression
Housing Opportunities for People with AIDS (HOPWA)	$103,000	Montana Department of Health	Housing Services	Linkage to Care, Retained in Care
Viral Hepatitis Funding				
CDC Viral Hepatitis Prevention Coordinator	$ 62,429	North Dakota Department of Health	Viral Hepatitis Prevention	HCV-Diagnosed, Linkage to Care,
State Funds for Viral Hepatitis	$200,000 /biennium	North Dakota Department of Health	Viral Hepatitis Testing, Vaccination and Education	HCV-Diagnosed, Linkage to Care

Workforce Capacity

The North Dakota Department of Health has an integrated HIV.STD.TB and Viral Hepatitis Program. This program consists of one program manager with four additional staff that serve in the following capacities: HIV.STD.Viral Hepatitis Surveillance Coordinator, HIV.STD.Viral Hepatitis Prevention Coordinator, TB Prevention & Control Coordinator, RW Part B Coordinator.

The HIV.STD.Viral Hepatitis Surveillance Coordinator is responsible for all surveillance activities related to the conditions listed. This individual is also responsible for ensuring that partner services are delivered in a timely and appropriate fashion to HIV contacts and for ensuring that all DIS staff are making the appropriate documentation of their attempts and successes at linking people to care.

The HIV.STD.Viral Hepatitis Prevention Coordinator is responsible for all prevention activities related to the conditions listed. This positon was created in a way that allowed for integration of activities related to prevention across diseases. This coordinator works with providers, local public health units, and other organizations to improve the prevention capacity in the state. The coordinator's primary responsibilities include coordinating testing programs for HIV/HCV, providing education to providers on prevention tools such as Prep and expedited partner therapy (EPT) for the treatment of STDs as well as providing education to the general public.

The TB Prevention & Control Coordinator primarily works with TB Prevention & Control, however the individual that is currently in that position also serves as the laboratory director in which non-clinical staff are certified to provide HIV & HCV CLIA waived point-of-care testing to expand the number of individuals who are able to provide testing services in the field.

The RW Part B Coordinator is responsible for the day-to-day administration of the Ryan White Part B and ADAP program in North Dakota. This individual works with contracted sites to ensure the appropriate provision of core and support services as well as with pharmacies to ensure appropriate access to medications.

Additional work is done at the local public health and provider level to provide contract services to people living with HIV as well as those at risk. There are currently twenty-two organizations that receive funding to provide HIV and HCV rapid and confirmatory testing in North Dakota. A subset of those sites also provide linkage-to-care for hepatitis C positive individuals and vaccination for hepatitis A and B to those who are either hepatitis C positive or high-risk negatives.

Ryan White Part B case management services are also integrated into 12 of the above sites to create a holistic approach to encompass all facets of the care continuum for PLWH. Individuals who test positive for HIV in North Dakota routinely see a team of individuals to ensure service provision is seamless. Many times, patients see both a DIS and RW case manager at the first appointment after diagnosis to talk about risk reduction, partners that need follow-up and

treatment and care services that are available to them should they qualify for Ryan White Part B services.

Some gaps that have been identified that warrant exploration include a deeper collaboration with substance abuse services to better integrate HIV and HCV testing and linkage to care for individuals seeking services at those locations. We know from other jurisdictions that the rising use of injectable drugs can and will lead to an increase in blood borne pathogen transmission. We feel that these partnerships must be built and that integration of testing services must become a standard for the treatment of substance abuse.

Assessing Needs, Gaps, and Barriers

HIV Prevention and Care Programs

The HIV Prevention Program is integrated within the HIV.STD.Viral Hepatitis Prevention Program at NDDoH. The primary function on the HIV/Viral Hepatitis Prevention Program is to manage the counseling, testing and referral (CTR) testing program. As of January 1, 2016, there are 22 primary CTR sites in North Dakota. These contracted CTR sites offer rapid and confirmatory HIV and hepatitis C testing, counseling, education and hepatitis A and B vaccination to those at risk for HIV and/or hepatitis C. Refer to Epidemiologic Profile for testing data from services offered at CTR sites. The services offered at CTR sites is free of charge and is intended for those who are uninsured or underinsured.

In addition to the CTR program, distribution of safer sex materials including condoms, safe sex kits, lube and dentals, education for healthcare providers and the general public and utilizing data to improve prevention efforts in North Dakota through quality management are functions of the HIV and Viral Hepatitis prevention program. Educational brochures, posters, videos and pamphlets are also distributed by the prevention program. The prevention program also relies on the efforts of DIS who investigate HIV positive cases to assist with efforts relating to prevention for positives and partner services. No DIS interventions are offered to individuals who have hepatitis C. Individuals infected with hepatitis B are interviewed and educated by field epidemiologists or their diagnosing healthcare provider. Positive HIV individuals are then referred to the Ryan White Program for care services.

The NDDoH- Division of Disease Control, administers the Ryan White Part B Program, and this is the only part for which North Dakota is funded. The eligibility criteria for N.D. Ryan White program include HIV diagnosis, North Dakota residency, and income below 400 percent of the federal poverty level. The Ryan White Part B funded services in N.D. include outpatient medical care, AIDS Drug Assistance Program (ADAP), case management, insurance premium assistance, dental and vision assistance, medical transportation, mental health and substance abuse services, nutritional supplement, and emergency assistance with rent and utilities.

The HIV Prevention and Ryan White Part B Program work together to provide a strategy and process that makes it possible for those diagnosed with HIV in North Dakota to have access to the services that these two programs provide in a seamless capacity. Having a small program and program office allows for clear coordination of activities and goal setting to ensure that there are not duplication and overlapping services occurring in the same locations.

These two programs also work together to provide information to PLWH and people at high risk for HIV infection about the process to engage as a stakeholder in the prevention and care planning process. Some examples of this include the collection of needs assessments, provider surveys and client satisfaction surveys. Results of these efforts are listed below.

Round-Table Discussions with PLWH in North Dakota

In 2015, Ryan White Program Coordinator and the Community Planning Group Facilitator held annual 8 Round-Table Discussion meetings with PLWH in 4 cities in North Dakota to provide information on available services such as the Ryan White program, Medicaid Expansion, Qualified Health Coverage through the Marketplace, patient assistance programs for those that do not qualify for RW, PrEP, STD screenings, housing assistance, mental health and substance abuse services, support groups and events for PLWH, and others. At these confidential meetings, attendees were encouraged to discuss their experiences with access to care and services, the roadblocks that they have experienced, where they feel the services are adequate, and where they feel the services are lacking. Attendees were also asked to fill out the 2013 Needs Assessment if they have not already done so.

PLWH participation was minimal, with 1 or 2 individuals showing up for each meeting. Majority of the participants were also Ryan White clients, and were well aware of and utilizing services they needed. However, the discussions are planned to be held annually despite the low participation rate, in hope that PLWH will become familiar with the organizers of the meetings, and become more willing to participate. Only two individuals that attended were non-RW clients, and stated the biggest need was for more education about existing services in North Dakota for PLWH.

Provider Survey

In January of 2016, 384 letters were sent to medical and support service providers in North Dakota to assess the scope and variety of services they provide. The providers included clinics, hospitals, student clinics, tribal health, family planning, refugee services, pregnancy centers, substance abuse/mental health facilities, Local Public Health Units, Community Actions, Federally Qualified Health Centers, and low-income dental and vision clinics. Sixty-three agencies (16%) replied to the survey as of February 29, 2016.

RW Satisfaction Survey

The client satisfaction survey is distributed by case managers annually. The clients rate the satisfaction with the services they have received in the past year, provide feedback on any issues and barriers that they experienced, and rank the services in order of importance to them. One hundred eighteen out of 168 active clients (70%) as of December 31, 2015 completed the satisfaction survey. Eight-four percent state they are very satisfied, and 16 percent are satisfied with the services they receive at their case management agency. Clients rank ADAP as the most important service followed by health insurance assistance, case management, outpatient medical care, and help with paying bills.

PLWH Needs Assessment

The Ryan White Program conducted a needs assessment in 2013 by mailing out paper survey to all PLWH, including RW clients. All infectious disease physicians were also mailed information on

how to distribute the survey information to their patients. Traditionally, participation of non-RW PLWH is hard to obtain in ND and majority of the needs assessment respondents (88%) were RW clients. Sixty-nine percent were males between the ages of 46 and 55 (31%). Forty-seven percent of the respondents identified as straight/heterosexual, and also 47% of participants identified as gay/lesbian. Six percent identified as bisexual. Sixty five percent were White and 24% African American or Black.

Table 4. People Living with HIV Needs Assessment (n=103)

PLWHA	
Ryan White Client	88%
Non-RW Client	8%
Country of Birth	
U.S. Born	78%
Non-U.S. Born	22%
Employment Status	
Employed Full-Time	40%
Disabled	30%
Unemployed	22%
Employed Part-Time	7%
Highest Level of Education Completed	
High School or Less	38%
Some College	35%
Associate's/Bachelor's Degree	26%
Post Graduate Degree	2%
AIDS Status	
HIV, Non-AIDS	75%
AIDS	25%
Place of Diagnosis	
Private Doctor or HMO	33%
Hospital/Emergency Room	14%
Public Health Center	25%
Age at Diagnosis	
14-25	17%
26-35	43%
36-45	31%
46+	9%
How do you think you were infected with HIV?	
Same Sex Contact	44%
Opposite Sex Contact	31%
Don't Know	12%
Sharing Needles	6%
How often do you see your medical provider?	
Never	0%
Once a year	11%
Twice a year	40%
Three or more times a year	47%
Have you been screened for the following:	
Chlamydia	67%
Gonorrhea	75%
Syphilis	76%
Hepatitis C	89%

Tuberculosis	96%
Satisfaction with Medical Provider	
Extremely Satisfied	76%
Somewhat Satisfied	11%
Neutral	9%
Unsatisfied	3%
Mode of Transportation to Medical Care (select all that you have used)	
My Car	88%
Volunteers, Friends, Family	46%
Walking	37%
Public Bus	37%
Borrowed Car	28%
Taxi	17%
Bicycle	13%
Transportation for the Disabled	11%
Traveling Distance to Medical Care (one way)	
Less than 25 miles	65%
26-50 miles	8%
51-100 miles	14%
101-200 miles	9%
More than 200 miles	3%
Traveling Distance to Support Services (i.e., case management, support groups, etc.)	
Less than 25 miles	80%
26-50 miles	7%
51-100 miles	7%
101-200 miles	5%
More than 200 miles	1%
Reasons for Delaying or Missing Regular Medical Care	
I couldn't afford it	53%
I didn't want to deal with my HIV status	40%
Medications made me ill	33%
Concern about confidentiality	27%
No insurance	27%
I was feeling well	13%

Service Needs

Ensuring adequate numbers of qualified healthcare providers are available in North Dakota is an essential service need for those at risk HIV and viral hepatitis. The services in North Dakota need to cater to a variety of demographics including those disproportionally affected in North Dakota including, 15-24 year old individuals, Native Americans and Black/African Americans. Healthcare providers, especially those in rural and underserved areas, need to offer comprehensive medical care including testing, treatment and preventive services for all types of sexually transmitted diseases (STDs), including HIV and viral hepatitis. These comprehensive services need to also be culturally competent for minority populations.

Education for those who are at-risk for HIV and viral hepatitis is very important. According to the 2015 North Dakota Youth Risk Behavior Survey, 54 percent of seniors in high school have had sexual intercourse. Ensuring prevention education for all types of STDs, including HIV and viral hepatitis at an appropriate age is essential to ensure what safe behavior choices are regarding sex and drugs. According to a survey conducted among men who have sex with men in North Dakota in 2014, only 50 percent of those survey were able to correctly answer the question on how HIV is transmitted.

Ensuring that healthcare services are available to those who are uninsured or underinsured is critical to confirm that all individuals at risk having adequate access to care.

Service Gaps

In North Dakota, service gaps occur mainly because of a low number of healthcare providers that are qualified to provide screening, treatment, care and prevention services for person at high risk for HIV and viral hepatitis. There are only six clinics in North Dakota that offer prevention services for HIV including pre-exposure prophylaxis (PrEP).

Based on surveillance data and investigations by the NDDoH, there are healthcare providers that do not understand proper screening protocols for HIV and viral hepatitis. These gaps in knowledge effect how individuals are screened, diagnosed and referred to care. Not only are screening algorithms a problem, but screening recommendations based on type of sex, i.e. men who have sex men and those having anal sex are not being screened appropriately for STDs.

The services provided by the NDDoH CTR sites does not reach the highest risk population. Only 15.7 percent of males tested at CTR sites are MSM. It is unknown if MSM in ND are seeking healthcare or if gaps or barriers as to why MSM are not receiving care. CTR sites also have provide testing services to a small percentage of injection drug users. In addition, injection drug use is not a commonly reported risk factor for HIV, the rates of injection drug use are reportedly on the rise in North Dakota. The rates of hepatitis C infection have been increasing substantially over the past five years. There are definite gaps in ensuring that injection and non-injection drug users are receiving proper healthcare especially being screened for HIV and viral hepatitis.

In a rural and low incidence state such as North Dakota, there is a limited access to infectious disease specialists, as well as to complete, coordinated, and consistent support services. Primary care physicians and other health care professionals often have limited knowledge of HIV and AIDS, and many are reluctant to treat HIV positive individuals, or provide PrEP. The Eastern part of the state is seeing the greatest gap relying on a single infectious disease physician to provide HIV related medical care.

Limited comprehensive services for low-income individuals such as stable and affordable housing, mental health and substance abuse services, disability benefits, meal assistance, affordable child-care, and affordable dental and vision care, all affect PLWH and their ability to seek care.

Service Barriers

The health department operates with the use of only federal funds for HIV prevention and limited state funds for a viral hepatitis program. With the availability of only federal funds for HIV prevention, there are limitations as to how funds are allotted. For example, HIV prevention funds cannot be used for the medication in a PrEP program. Limited funds also limit the program activities and also the number of staff in the program. Because of the small number of staff in our program, staff have multiple duties and prioritization of responsibilities is necessary.

The health department also has barriers in the availability of testing and laboratory data. The testing data available to the NDDoH is from the NDDoH Division of Laboratory Services and this data is mainly from sites funded by the NDDoH. Limited information is available from private healthcare facilities to determine trends in testing and screening.

Many positive individuals still feel that stigma is associated with having HIV, and fear that disclosure of their status will have negative repercussions for them. They are reluctant to seek services in their community, and travel long distances to receive medical care in order to protect their confidentiality. The fear of disclosure of their status prevents them from getting all the support care that they need in order to lead a healthy productive life. The stigma and fear also contributes to the lack of HIV positive community and participation in activities such as support groups, which leads to a sense of aloneness and isolation, and decreases the quality of life of PLWH. PLWH not only experience stigma related to their HIV, but also stigma associated with their sexual or gender orientation, and other factors commonly related to HIV such as mental health issues, substance abuse, and socio-economic issues.

Over the past five years, there has been a change in the demographic of PLWH in North Dakota to reflect the national trend of the epidemic. In recent years, there has been an increase in the number of females, Black/African Americans, and refugees living with HIV in North Dakota. Proving care to racial minorities such as Black or African Americans may present racial barriers. Cultural and language barriers, coupled with unfamiliarity with navigating the intricate system of U.S. healthcare and health coverage experienced by refugees and asylum seekers may result in delayed testing and care, with presenting for care upon onset of physical symptoms leading to poorer outcomes, and poorer quality of life.

With the excellent antiretroviral HIV treatments, HIV has become a chronic condition that is relatively easy to treat, from once untreatable disease with high mortality rate. However, this poses new challenges in the management of HIV care, as the positive individuals are starting to age. These include additional health issues caused by the long-term infection, and possible side effects of the long-term ARV use.

Increased survival rates of PLWH also contribute each year to a growing number of clients on the RW program, which burdens the caseloads of the existing case managers. The program does not have full-time case managers, and the fact that most existing case managers only devote a small part of their time to the Ryan White client hinders the quality of services and care clients

receive. Clients often need encouragement from case managers to deal with issues and barriers, and consistently stay in medical care and treatment. Without case managers help, clients often fail to improve medically and remain to struggle with unresolved financial or health issues.

The Affordable Care Act (ACA) provided previously uninsurable HIV positive individuals with an opportunity to get health coverage through either the Marketplace, or the Medicaid Expansion. This has been of vital importance to low-income individuals, and those below 400% FPL on RW program. However, even with options to obtain affordable insurance, some individuals still remain uninsured, or find the cost of the insurance, medical care, and treatment unaffordable. Ryan White program has been able to adequately cover all medical and treatment expenses related to HIV for those enrolled. However, PLWH not enrolled in the program, or HIV negative individuals seeking PrEP, see the cost of the medical care, treatment, and insurance as a barrier.

With the implementation of ACA and the individual mandate of each person's responsibility to get insured, get an exemption, or pay the penalty, many individuals who previously had no access to insurance due to pre-existing conditions were able to get insurance since 2014. This has shifted the expenses from public programs such as Ryan White to private insurance carriers, and unburdened the program to assist with other necessary expenses such as housing, dental/vision care, and others. However, the complex system poses a barrier to some individuals, especially those born outside of U.S, who are not familiar with the existing health care system. Language and cultural barriers add to the feeling of being overwhelmed, and often, these individuals remain uninsured.

HIV specialists are concentrated in more populated areas, obligating individuals to travel long distances to receive specialized care and to participate in support and planning groups. Thirty-five percent of PLWH report traveling over 25 miles in one direction to the medical provider. Some individuals prefer leaving their small towns and traveling to bigger cities to receive care, testing, and support services in order to protect their identity. However, for many PLWH access to transportation is a barrier to care. Many low-income individuals do not own their own vehicles, and rely on friends and family to drive them to their appointments. Forty-six percent report relying on volunteers, family members, or friends for transportation at least once. Transportation gap is biggest in the Eastern part of the state where PLWH rely on a single infectious disease provider located 120 miles away from one of the cities with most PLWH.

Social determinants of health including the conditions in which people are born, live, work and age, heavily influence the cause and course of HIV. Therefore, poverty, homelessness, low education level, mental health issues, substance abuse, co-morbidities, and others, contribute to higher risk of infection, and pose as barriers to adequate essential medical care and treatment for PLWH.

Data: Access, Sources, and Systems

Data Sources

Data were compiled from a number of sources to present the most complete picture of the epidemiology of diseases as possible. However, because few behavioral or supplemental surveillance projects are available in North Dakota, core surveillance data will be utilized heavily. Each data source has strengths and limitations. A brief description of each source follows.

HIV/AIDS Data Sources

HIV / AIDS Case Surveillance

A diagnosis of HIV/AIDS is mandatorily reportable to the NDDoH according to North Dakota Century Code Chapter 23-07-01 and North Dakota Administrative Code Chapter 33-06-01. Physicians, hospitals, laboratories, and other institutions can provide reports of HIV/AIDS cases. These data are stored in the electronic HIV/AIDS Reporting System (eHARS) and MAVEN databases. Statistics and trends presented in this report were derived from HIV/AIDS case data reported to the NDDoH cumulatively from 1984 through Dec. 31, 2015.

HIV Counseling and Testing Data

Counseling and Testing and Referral (CTR) system

NDDoH funds 21 free, confidential HIV testing and counseling sites in North Dakota, and holds contracts with all sites providing rapid testing. Participants complete risk assessments as part of a testing visit or during outreach. Risk factors of the patients that receive tests through this program are reported to NDDoH.

HIV Care Data

Ryan White Part B Program

North Dakota Ryan White Part B Program (formerly known as North Dakota CARES) assists low-income North Dakota residents living with HIV or AIDS to access confidential health and supportive services. The program was implemented in 1991. In order to be a part of the ND Ryan White Part B Program, one must be a resident of North Dakota, have a gross income less than 300 percent of the current Federal Poverty Level, and have proof of HIV infection.

Part B services include core and supportive medical services. Core services include outpatient/ambulatory medical services, AIDS Drug Assistance Program (ADAP), oral health care, health insurance premium assistance, mental health services and medical case management. Supportive services such as non-medical case management, housing services, medical transportation services and emergency financial assistance.

The Ryan White Part B Program implemented the surveillance system MAVEN for client data management in 2012. MAVEN houses HIV prevention, surveillance, and Ryan White data, and has created a seamless integration and sharing of information between these programs. MAVEN houses data from all Part B providers, including the ADAP. Utilization of the current version of MAVEN will ensure that all required client-level data elements will be collected by

providers and reported to HRSA. The "real time" nature of the networked system allows the Ryan White Part B Program to monitor specific indicators more closely (e.g., number of clients without medical insurance), as well as gives access to case managers to view client's lab work and medication so that client can be managed more effectively.

MAVEN allows the sharing of information between agencies, thereby improving access and timeliness to care and medication, and improving the tracking of quality indicators. Information collected from the service providers includes basic demographic and risk information, eligibility verification data (current address, income, insurance information and policy numbers), the type of services received, the date and quantity of services received, the cost of these services, the name of agency and case manager that provided these services, and other pertinent information (history of substance abuse or mental health treatment, veteran status). Each client is assigned to his or her case manager in MAVEN. The surveillance program collects additional information (pregnancy status, HIV diagnosis date, lab work), and prevention collects partner information. The data indicate which Ryan White resources are being used, how often, and by whom. However, these data only reflect persons who (1) know their HIV sero-status, (2) are currently seeking care and treatment services from Ryan White Part B-funded providers, and (3) are financially eligible to receive services.

Viral Hepatitis Surveillance Data

The Hepatitis Program receives reports of hepatitis A, B and C acute and chronic infections from various reporting sources. Hepatitis B infections are investigated to determine if post exposure immune-prophylaxis procedures for contacts were followed. Women of childbearing age, 14-44 years, that are hepatitis B positive, are followed-up to determine if they are pregnant. The perinatal Hepatitis B Prevention coordinator in the immunization program then follows pregnant women who are hepatitis B positive. The coordinator ensures the hospital has hepatitis B immune globulin (HBIG) for administration to the baby at time of delivery. The coordinator also confirms the baby is started on the hepatitis B vaccine series and ensures serology testing is done at completion of the vaccine series. This is to ensure the child is not infected and is immune to the hepatitis B virus.

Cases of Hepatitis C that are reported as acute are followed with a case investigation. Only demographic information is collected for all other reported Hepatitis C cases. Under reporting of both acute and chronic Hepatitis C infections in North Dakota is likely. Hepatitis C virus infection (past or present (chronic hepatitis C)) classification is given to those infected with the hepatitis C virus and the numbers do not distinguish between resolved and active infections. The health department does not conduct case interviews and partner notification.

Vital Statistics Data

Birth and Death Data

NDDoH, Division of Vital Statistics collects information on all births and deaths in North Dakota. The birth certificate form includes demographic information on the newborn infant and the parents, prenatal care, maternal medical history, mode of delivery, events of labor, and

abnormal conditions of the infant. Death certificates include demographics, underlying cause of death, and factors contributing to the death. The surveillance program review death certificates on a weekly basis to ascertain deaths of HIV positive persons. The surveillance program also electronically matches data with death and birth databases annually to ascertain deaths of persons with HIV/AIDS and births to HIV-infected women.

Population Data

U.S. Census Bureau

The Census Bureau collects and provides timely information about the people and economy of the United States. The Census Bureau Web site (http://www.census.gov) includes data on demographic characteristics (e.g., age, race, ethnicity, and sex) of the population, family structure, educational and income level, housing status, and the proportion of persons who live at or below the poverty line. Summaries of the most requested information for states and counties are provided, as well as analytical reports on population changes, age, race, family structure, and apportionment. State- and county-specific data are easily accessible, and links to other web sites with census information are included.

SECTION II: INTEGRATED HIV AND VIRAL HEPATITS PREVENTION AND CARE PLAN

Integrated HIV and Viral Hepatitis Prevention and Care Plan

GOAL 1: Reduce New HIV and Viral Hepatitis Infections.

Objective 1: By 2021, Lower the Annual Number of New HIV Infections Among MSM by 50%.

Strategy 1.1: Increase Outreach and Targeted Testing Among High-Risk Populations.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Increase the number of MSM tested for HIV by 10% per year at outreach testing events.	HIV Prevention Coordinator, and HIV Surveillance Programs Coordinator and CPG Facilitator.	MSM.	• Number of Events in which MSM were tested. • Number of MSM tested.
By December 31, 2021	Monitoring screening rates among HIV positive MSM for STDs.	HIV Prevention and HIV Surveillance Coordinators.	Healthcare Providers to PLWH.	• Number of PLWH tested for STDS. • Number of charts reviewed.
By December 31, 2021	Document at least one named and HIV tested partner per new diagnosis among MSM for follow-up by partner services.	HIV Surveillance Coordinator and NDDoH Field Epidemiologists.	Newly Diagnosed HIV MSM Cases.	• Number of named partners per HIV case. • Number of named partners tested for HIV.
Needed Resources/Gaps in Care Continuum/Challenges: Resources needed to complete these activities are available. These activities aim to increase the number of individuals whom are infected are now aware of their HIV diagnosis. One challenge noted in completing these activities is ensuring the NDDoH field epidemiologists are provided with the tools and education to increase the effectiveness of partner services.				

Strategy 1.2: Increase Knowledge, Availability and Utilization of PrEP in North Dakota.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2017	Develop campaign materials for MSM advertising PrEP in North Dakota.	HIV Prevention Coordinator and Community Planning Group.	MSM.	• Number of educational materials developed. • Number of educational materials distributed.
By December 31, 2021	Provide education to five healthcare providers each year that see a high volume	HIV Prevention Coordinator.	Healthcare Providers.	• Number of trainings on PrEP offered. • Number of

	of patients who may be eligible for PrEP.			Providers Offering PrEP.
By December 31, 2021	Collect data yearly from pharmacies or insurance companies on the number of PrEP prescriptions.	HIV Prevention Coordinator.	Healthcare Providers. High Risk Individuals.	• Number of PrEP prescriptions given.
Needed Resources/Gaps in Care Continuum/Challenges: Data relating to PrEP prescriptions is a resource that is not readily available. The HIV program will need to develop new relationships to acquire this information.				

Strategy 1.3: Expand Condom Distribution in North Dakota.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By July 31, 2017	Compare HIV and STD morbidity to healthcare providers requesting condoms and identify areas in ND lacking in condom distribution.	HIV Surveillance Coordinator and HIV Prevention Coordinator.	High Risk Individuals. MSM. Native Americans.	• Map of ND created with condom distributions sites.
By December 31, 2017	Determine the option as to whether home distribution of condoms in applicable in ND and develop program.	HIV Program Manager.	Youth. Rural ND. MSM.	• Number of condom distribution programs in ND.
By December 31, 2021	Distribute condoms to an additional ten sites per year based on high-risk areas.	HIV Prevention Coordinator.	High Risk Individuals. MSM. Native Americans.	• Number of newly identified condom distribution sites. • Number of condoms distributed.
Needed Resources/Gaps in Care Continuum/Challenges: No additional resources are needed for these activities. In a conservative state, it may be challenging to gain approval to utilize different strategies to distribute condoms may not be approved.				

Objective 2: By 2021, Lower the Annual Number of New HIV Infections Among Native Americans by 50%.

Strategy 2.1: Increase Outreach and Targeted Testing Among Native Americans.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Increase the number of Native Americans tested for HIV by 10% per year at outreach testing events.	HIV Prevention Coordinator, and HIV Surveillance Programs Coordinator and CPG Facilitator.	Native Americans.	• Number of Events in which Native Americans were tested. • Number of Native Americans tested.
By December 31, 2021	Monitoring screening rates among HIV positive Native Americans for STDs.	HIV Prevention and HIV Surveillance Coordinators.	Healthcare Providers to PLWH.	• Number of PLWH tested for STDS. • Number of charts reviewed.
By December 31, 2021	Document at least one named and HIV tested partner per new diagnosis of HIV and Gonorrhea among Native Americans for follow-up by partner services.	HIV Surveillance Coordinator and NDDoH Field Epidemiologists.	Newly Diagnosed HIV MSM Cases. Diagnosed GC Cases.	• Number of named partners per HIV case. • Number of named partners tested for HIV. • Number of named partners per Gonorrhea case.
Needed Resources/Gaps in Care Continuum/Challenges: Resources needed to complete these activities are available. These activities aim to increase the number of individuals whom are infected are now aware of their HIV diagnosis. One challenge noted in completing these activities is ensuring the NDDoH field epidemiologists are provided the tools and education to increase the effectiveness of partner services.				

Strategy 2.2: Increase Knowledge, Availability and Utilization of PrEP among Providers serving Native Americans.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2017	Develop campaign materials for Native Americans advertising PrEP in North Dakota. These materials will have a focus on PWID.	HIV Prevention Coordinator and Community Planning Group.	MSM.	• Number of educational materials developed. • Number of educational materials distributed.
By December 31, 2021	Provide education to five healthcare providers each year that see a high volume of patients who may be eligible for PrEP.	HIV Prevention Coordinator.	Healthcare Providers.	• Number of trainings on PrEP offered. • Number of Providers Offering PrEP.

By December 31, 2021	Collect data yearly from pharmacies or insurance companies on the number of PrEP prescriptions.	HIV Prevention Coordinator.	Healthcare Providers. High Risk Individuals.	Number of PrEP prescriptions given.
Needed Resources/Gaps in Care Continuum/Challenges: Data relating to PrEP prescriptions is a resource that is not readily available. The HIV program will need to develop new relationships to acquire this information.				

Strategy 2.3: Expand Condom Distribution on American Indian Reservations.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By July 31, 2017	Compare HIV and STD morbidity to healthcare providers requesting condoms and identify areas in ND lacking in condom distribution.	HIV Surveillance Coordinator and HIV Prevention Coordinator.	High Risk Individuals. MSM. Native Americans.	• Map of ND created with condom distributions sites.
By December 31, 2021	Distribute condoms to an additional ten sites per year based on high-risk areas.	HIV Prevention Coordinator.	High Risk Individuals. MSM. Native Americans.	• Number of newly identified condom distribution sites. • Number of condoms distributed.
By December 31, 2017	Determine the option as to whether home distribution of condoms in applicable in ND and develop program.	HIV program manager.	Youth. Rural ND. MSM.	• Number of condom distribution programs in ND.
Needed Resources/Gaps in Care Continuum/Challenges: No additional resources are needed for these activities. In a conservative state, it may be challenging to gain approval to utilize different strategies to distribute condoms.				

Objective 3: By 2021, Lower the Annual Number of New Hepatitis C Infections among People Under 30 Years by 50%

Strategy 3.1: Increase Outreach and Targeted Testing Among people who inject drugs (PWID).

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Increase the number of PWID tested for HIV and HCV by 10% per year at outreach testing events.	HIV/HCV Prevention Coordinator and CPG Facilitator.	PWID	• Number of Events in which PWID were tested. • Number of PWID tested.
By December 31, 2017	Develop protocol for surveillance for acute hepatitis C investigations.	HCV Surveillance Coordinator and DIS.	PWID.	• Protocol Developed. • Number of contacts tested because of investigations.
Needed Resources/Gaps in Care Continuum/Challenges: Additional resources needed to complete these activities include additional personnel or restructuring of current responsibilities. These activities aim to increase the number of individuals whom are infected are now aware of their HCV diagnosis. One challenge noted in completing these activities is ensuring the NDDoH field epidemiologists are provided the tools and education to increase the effectiveness of partner services.				

Strategy 3.2: Ensure North Dakotans have access to hepatitis C treatment.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By July 31, 2017	Develop protocol for the reporting of patients who are being treated for hepatitis C.	Hepatitis Prevention Coordinator.	Healthcare providers.	• Protocol developed. • Number of individuals successfully treated for hepatitis C.
By December 31, 2018	Develop protocol for follow up of individuals who have not received appropriate confirmatory testing for HCV.	Hepatitis Prevention Coordinator.	Healthcare providers.	• Protocol developed. • Number of individuals not receiving confirmatory testing.
By December 31, 2021	Establish linkage to care program for hepatitis C positive individuals.	Hepatitis Prevention Coordinator and Hepatitis Program Manager.	Hepatitis C Positive Individuals.	• Development of a program. • Number of hepatitis C patients linked or re-engaged in care.
Needed Resources/Gaps in Care Continuum/Challenges: Limited funding and staff is available for a viral hepatitis program. Without these two resources, accomplishing this objective will be challenging. The activities will address the gap in the care continuum relating to number of patients receiving confirmatory testing and being linked to care.				

Strategy 3.3: Ensure syringe access is a part of harm reduction in North Dakota.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Implement a syringe access program in ND.	Hepatitis Program Manager & Hepatitis Prevention Coordinator.	PWID.	• Development of a program.
By December 31, 2021	Provide education on syringe exchange programs to IHS.	Hepatitis Prevention Coordinator.	PWID.	• Number of education sessions provided to IHS. • Number of syringe exchanges programs developed by IHS.
By December 31, 2019:	Work with partners to arrange for safe needle disposal programs in ND.	Hepatitis Program Manager & Hepatitis Prevention Coordinator.	PWID.	• Development of a program.
Needed Resources/Gaps in Care Continuum/Challenges: The biggest challenge and needed resource for this objective relates to policy education and change. Syringe exchange is not legal in North Dakota and there is limited movement to change those policies currently.				

GOAL 2: Increase Access to Care and Improve Health Outcomes for PLWH & Viral Hepatitis

Objective 1: By 2021, Offer 100% of PLWH in ND access to a case management program.

Strategy 1.1: All PLWH will have access to case management.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Establish a linkage care program.	HIV Program Manager and Ryan White Coordinator.	PLWH.	• Creation of a linkage to care program. • Number of clients enrolled. • Number of clients linked to care.
By December 31, 2021	Develop educational materials for PLWH.	HIV Program Manager and Ryan White Coordinator.	PLWH.	• Number of educational materials developed. • Number of educational materials distributed.
Needed Resources/Gaps in Care Continuum/Challenges: Sustaining secure funding to establish and maintain this program will be very important for this objective. These activities will reduce the gaps seen among clients engaged in care, targeted specifically towards non-Ryan White clients.				

Strategy 1.2: All PLWH will be reengaged in care.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2017	Establish linkage to care and reengagement to care protocol for DIS.	HIV Program Manager and Ryan White Coordinator.	PLWH.	• Protocol development.
By December 31, 2021	Increase the number of HIV positive persons engaged in care to 95%.	HIV Program Manager, Ryan White Coordinator, DIS	PLWH.	• Number of clients DIS contacted. • Number of clients reengaged to care by DIS.
Needed Resources/Gaps in Care Continuum/Challenges: One challenge for the success of this activity relies on our ability to have current contact information for PLWH. Additional resources are not required. This activity will reduce the gaps seen among clients engaged in care, targeted specifically towards non-Ryan White clients.				

Strategy 1.3: All PWLH will be provided patient education.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2017	Develop materials to be given to newly diagnosed PLWH that contains information on HIV and resources in North Dakota.	HIV Prevention Coordinator and Ryan White Coordinator.	PWLH.	• Materials Developed. • Number of Clinics with Materials. • Number of Materials Distributed.
Needed Resources/Gaps in Care Continuum/Challenges: None noted.				

Objective 2: By 2021, 100% of HIV Diagnosed Patients are Screened for Tuberculosis (TB) and Treated if Necessary.

Strategy 2.1: Ensure healthcare providers are properly educated.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Provide onsite educational visits for two healthcare providers each year.	TB Controller and HIV Prevention Coordinator.	Healthcare providers.	• Number of educational visits conducted. • Number of PLWH treated for TB.
By December 31, 2017	Establish baseline date for TB screening among PLWH.	TB Controller and HIV Prevention Coordinator.	PLWH who co-infected with TB.	• Number of PLWH screened for TB. • Number of PLWH co-infected with TB.
By December 31, 2017	Development of TB newsletter.	TB Controller and HIV Prevention Coordinator.	Healthcare providers.	• Number of newsletters sent to healthcare providers.
By December 31, 2017	Develop provider-detailing reports that include missed opportunities and successes.	TB Controller and HIV Prevention Coordinator.	Healthcare providers.	• Number of reports distributed. • Number of missed opportunities identified each year.
Needed Resources/Gaps in Care Continuum/Challenges: Additional resources are not anticipated. Utilizing expertise of the regional TB resource center will also help accomplish these activities.				

Strategy 2.2: Provide education to PLWH about TB.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Development of brochure and educational materials.	TB Controller and HIV Prevention Coordinator.	PLWH.	• Number of educational materials developed. • Number of educational materials distributed.
By December 31, 2021	Ensure that PLWH are screened for TB if there are at continued risk.	TB Controller and HIV Prevention Coordinator.	PLWH	• Number of PLWH screened for TB.
Needed Resources/Gaps in Care Continuum/Challenges: Additional resources are not anticipated. Utilizing expertise of the regional TB resource center will also help accomplish this activities.				

Strategy 2.3: Utilize TB case managers and Ryan White coordinators to ensure case management occurs for all co-infected HIV and TB patients.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Identify all HIV positive individuals who have TB and diabetes.	TB Controller and HIV Surveillance Coordinator.	PLWH co-infected with TB.	• Protocol developed for checking TB status of all newly diagnosed HIV. • Number of PLWH co-infected

				with TB.
By December 31, 2021	Provide treatment via directly observed therapy (DOT).	TB Controller.	PLWH co-infected with TB.	• Number of patients provided DOT.
Needed Resources/Gaps in Care Continuum/Challenges: Limited staff are available for DOT. Establishing priorities with TB nurses in North Dakota may be a challenge if additional resources are not available to provide reimbursement for DOT.				

Objective 3: By 2021, ensure that there is a treating HIV provider within 50 miles of every PLWH.

Strategy 3.1: Assess the gaps in care for PLWH.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2017	Determine areas with gaps in care.	HIV Prevention Coordinator.	Healthcare providers. PLWH.	• Number of PLWH that travel more than 50 miles to see a provider.
By December 31, 2018	Identify Healthcare Providers in areas in which gaps exist to treat for HIV.	HIV Prevention Coordinator.	Healthcare providers. PLWH.	• Number of providers willing to treat HIV.
Needed Resources/Gaps in Care Continuum/Challenges: Expertise in GIS mapping is needed to complete these activities. Identifying providers in rural North Dakota that are willing to treat HIV is another challenge.				

Strategy 3.2: Ensure healthcare providers are educated to provide HIV treatment.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2018	Develop a HIV treatment toolkit for healthcare providers.	HIV Prevention Coordinator and Ryan White Coordinator.	Healthcare providers.	• Toolkit Developed. • Number of toolkits distributed.
By December 31, 2021	Provide education to healthcare providers interested in treating HIV patients.	HIV Prevention Coordinator.	Healthcare providers.	• Number of educational sessions offered. • Number of providers educated.
Needed Resources/Gaps in Care Continuum/Challenges: The need for additional resources is not expected. Identifying providers in rural North Dakota that are willing to treat HIV is a challenge.				

Strategy 3.3: Increase the number of healthcare providers providing care to PLWH.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Engage healthcare facilities in telemedicine.	HIV Prevention Coordinator.	Healthcare Providers.	• Number of healthcare facilities offering telemedicine for PLWH.
By December 31, 2021	Engage various provider types including primary care into the treatment of HIV.	HIV Prevention Coordinator.	Healthcare Providers.	• Number of providers treating PLWH.
Needed Resources/Gaps in Care Continuum/Challenges: Resources are not available to encourage facilities to offer telemedicine and programs may need to be developed around existing telemedicine. Finding healthcare providers to take on additional specialties may be a challenge.				

Objective 4: By 2021, Increase the Number of Hepatitis C Positive Patients Treated by 10%.

Strategy 4.1: Ensure reporting of hepatitis C treatment by healthcare providers.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By July 31, 2017	Develop protocol for the reporting of patients who are being treated for hepatitis C.	Hepatitis Prevention Coordinator.	Healthcare providers.	• Protocol developed. • Number of individuals successfully treated for hepatitis C.
Needed Resources/Gaps in Care Continuum/Challenges: Additional resources are not needed. Challenges already exist in reporting by healthcare providers. Ensuring compliance with additional reporting requirements by healthcare providers may be difficult. This activity will allow the NDDoH to create a more accurate hepatitis C care cascade.				

Strategy 4.2: Provide education to healthcare providers on hepatitis C.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2017	Develop reports to providers based on the hepatitis C treatment from their clinic.	Hepatitis Prevention Coordinator.	Healthcare Providers.	• Developed report. • Number of reports distributed.
By December 31, 2021	Education to providers offering hepatitis C treatment.	Hepatitis Prevention Coordinator.	Healthcare Providers.	• Number of healthcare providers educated.
Needed Resources/Gaps in Care Continuum/Challenges: The need for additional resources nor are challenges are expected.				

Strategy 4.3: Utilize telemedicine to increase opportunities for individuals to be treated for hepatitis C.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Collaborate with healthcare facilities to offer telemedicine at rural locations in North Dakota.	Hepatitis Prevention Coordinator.	Healthcare Providers.	• Number of healthcare facilities are hepatitis C telemedicine.
Needed Resources/Gaps in Care Continuum/Challenges: Resources are not available to encourage facilities to offer telemedicine. Programs may need to be developed around existing telemedicine. In areas in which the healthcare structure is already at capacity, finding healthcare providers to take on additional specialties may be a challenge.				

GOAL 3: Reducing HIV & Viral Hepatitis Related Health Disparities

Objective 1: By 2021, the CPG will Hold 10 Events per Year Aimed at Reducing Stigma Surrounding HIV/AIDS and viral hepatitis in North Dakota.

Strategy 1.1: Reduce stigma through broad community education.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Provide education and testing at various locations and event types in North Dakota.	HIV/Hepatitis Prevention Coordinator and CPG.	North Dakota Communities. At-Risk Individuals.	• Number of education events participated.
By December 31, 2021	Develop educational materials that can be distributed throughout North Dakota.	HIV/Hepatitis Prevention Coordinator and CPG.	North Dakota Communities. At-Risk Individuals.	• Number of brochures developed. • Number of brochures distributed.
Needed Resources/Gaps in Care Continuum/Challenges: The need for additional resources nor are challenges are expected.				

Strategy 1.2: Reduce stigma through mass communication.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2018	Develop educational campaign in ND.	HIV/Hepatitis Prevention Coordinator and CPG.	North Dakota Communities. At-Risk Individuals.	• Campaign developed. • Campaign Advertisement.
By December 31, 2021	Develop best practice strategies for social media for the community planning group and HIV & Viral Hepatitis Prevention Programs.	HIV/Hepatitis Prevention Coordinator and CPG.	North Dakota Communities. At-Risk Individuals.	• Best Practices Develop. • Number of social media efforts.
By December 31, 2021	Develop website for CPG.	HIV/Hepatitis Prevention Coordinator and CPG.	North Dakota Communities. At-Risk Individuals.	• Website Developed. • Number of viewers.
Needed Resources/Gaps in Care Continuum/Challenges: To create an educational campaign with widespread impact, funding may dictate the success level of the campaign. Ensuring that staff from NDDoH and CPG are trained in how to use social media to your advantage may be a challenge that needs to be address early in 2017.				

Strategy 1.3: Reduce stigma through targeted education.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Develop curriculum for stigma education.	HIV/Hepatitis Prevention Coordinator and CPG.	North Dakota Communities.	• Curriculum Developed. • Number of Times Curriculum Utilized.
By December 31, 2021	Offer training to healthcare providers on providing care free of stigma.	HIV/Hepatitis Prevention Coordinator and CPG.	Healthcare providers.	• Number of healthcare providers educated.
Needed Resources/Gaps in Care Continuum/Challenges: The NDDoH and CPG will need technical assistance to ensure that materials and trainings offered are sufficient at addressing the issue of stigma.				

Objective 2: By 2021, the North Dakota Department of Health will create and institute a program aimed at educating youth and parents about HIV/viral hepatitis prevention.

Strategy 2.1: Provide education to youth in North Dakota at schools.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Bring HIV positive individual to schools as a Speaker.	HIV Prevention Coordinator.	Youth.	• Number of times a speaker presented. • Number of schools requesting speaker.
By December 31, 2021	Develop peer AIDS Program.	HIV Prevention Coordinator.	Youth.	• Development of Program. • Number of participating youth.
Needed Resources/Gaps in Care Continuum/Challenges: Ensuring that there will be interest and investment from schools prior to the beginning these activities will be necessary.				

Strategy 2.2: Provide education to youth and their parents.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2018	Develop educational campaign in ND.	HIV/Hepatitis Prevention Coordinator and CPG.	North Dakota Communities. At-Risk Individuals.	• Campaign developed. • Campaign Advertisement.
By December 31, 2021	Develop best practice strategies for social media for the community planning group and HIV & Viral Hepatitis Prevention Programs.	HIV/Hepatitis Prevention Coordinator and CPG.	North Dakota Communities. At-Risk Individuals.	• Best Practices Develop. • Number of social media efforts.
By December 31, 2021	Develop website for CPG.	HIV/Hepatitis Prevention Coordinator and CPG.	North Dakota Communities. At-Risk Individuals.	• Website Developed. • Number of viewers.
Needed Resources/Gaps in Care Continuum/Challenges: To create an educational campaign with widespread impact, funding may dictate the success level of the campaign. Ensuring that staff from NDDoH and CPG are trained in how to use social media to your advantage may be a challenge that needs to be address early in 2017.				

Strategy 2.3: Develop targeted education for youth and their parents in North Dakota.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2018	Conduct focus groups in North Dakota for various populations to determine needed education.	HIV/Hepatitis Prevention Coordinator and CPG.	North Dakota Communities. At-Risk Individuals.	Number of focus groups conducted.
By December 31, 2018	Hold community forums to discuss needs relating to HIV and viral hepatitis.	HIV/Hepatitis Prevention	North Dakota Communities.	Number of community forums discussed.

		Coordinator and CPG.	At-Risk Individuals.	
By December 31, 2021	Collaborate with Parents Lead in North Dakota to create information on how parents can talk to their kids about sex.	HIV/Hepatitis Prevention Coordinator and CPG.	North Dakota Communities. At-Risk Individuals.	Campaign develop. Number of times campaign distributed.
Needed Resources/Gaps in Care Continuum/Challenges: Obtaining relevant and helpful information from community forums may be challenging. Ensuring that these activities lead to meaningful discussion and not bring forth fear of stigma and discrimination is a concern for communities in North Dakota.				

GOAL 4: Achieving a More Coordinated Response

Objective 1: By 2021, ensure 15 healthcare facilities provide comprehensive medical services.

Strategy 1.1: Perform assessments of healthcare facilities and their offering of comprehensive medical services.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Provide assessment to healthcare providers each year on their level of integration of HIV and viral hepatitis into their practice.	HIV/Viral Hepatitis Prevention Coordinator, HIV.STD.Viral Hepatitis Surveillance Coordinator and Field Epidemiologists.	Healthcare providers.	• Number of assessments provided. • Number of onsite educational visits.
Needed Resources/Gaps in Care Continuum/Challenges: None noted.				

Strategy 1.2: Collaborate with healthcare providers to conduct quality improvement.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2021	Provide quality improvement plans to healthcare providers each year based on their integration assessment.	HIV/Viral Hepatitis Prevention Coordinator, HIV.STD.Viral Hepatitis Surveillance Coordinator and Field Epidemiologists.	Healthcare providers.	• Number of quality improvement plans developed. • Number of quality improvement plans executed.
Needed Resources/Gaps in Care Continuum/Challenges: None noted.				

Strategy 1.3: Develop materials for best practices of integration for healthcare providers.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2018	Develop a holistic service directory.	HIV.STD.Viral Hepatitis Prevention Coordinator.	North Dakota Communities. At-Risk Individuals. Healthcare providers.	• Number of quality improvement plans developed. • Number of quality improvement plans executed.
By December 31, 2021	Develop a toolkit for best practices for HIV, STD and viral hepatitis prevention in the clinic setting.	HIV.STD.Viral Hepatitis Prevention Coordinator.	Healthcare providers.	• Toolkit Developed. • Number of Toolkits Distributed.
Needed Resources/Gaps in Care Continuum/Challenges: None noted.				

Objective 2: By 2021, develop a surveillance protocol that can detect and monitor early warning signs of emerging or potential HIV and HCV outbreaks.

Strategy 2.1: Develop relationships with partners from different data sources.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2018	Develop syndrome listing that could monitor potential HIV and hepatitis C outbreaks.	HIV Prevention Coordinator and Syndromic Surveillance Coordinator.	High Risk Individuals.	• Protocol for syndrome surveillance for HIV and HCV developed.
By December 31, 2021	Develop relationships with entities to replicate the vulnerability index for North Dakota.	HIV Prevention Coordinator and Syndromic Surveillance Coordinator.	High Risk Individuals.	• Number of additional data sources accessed. • Vulnerability index for ND created.
Needed Resources/Gaps in Care Continuum/Challenges: The HIV.STD.Viral Hepatitis program will need to rely on other programs areas within the Division to accomplish these activities. Ensuring that these activities are made a priority will be a challenge.				

Strategy 2.2: Utilize surveillance tools to detect potential outbreaks.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2019	Develop reports for MAVEN to monitor trends and emerging concerns.	HIV Prevention Coordinator, Data Processing Coordinator and NEDSS Coordinator.	Newly diagnosed HIV and hepatitis C cases.	• Number of reports developed. • Number of investigations.
By December 31, 2021	Modify existing outbreak management system within MAVEN.	HIV Prevention Coordinator, Data Processing Coordinator and NEDSS Coordinator.	Outbreak related cases and contacts.	• Development of outbreak management system.
Needed Resources/Gaps in Care Continuum/Challenges: The HIV.STD.Viral Hepatitis program will need to rely on other programs areas within the Division to accomplish these activities. Ensuring that these activities are made a priority will be a challenge.				

Strategy 2.3: Develop outbreak response plans and protocols.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By December 31, 2019	Develop outbreak response plan for HIV.	All members of NDDoH HIV.STD.Viral Hepatitis program.	Newly diagnosed HIV cases.	• Outbreak response plan developed.
By December 31, 2019	Develop outbreak response plan for viral hepatitis.	All members of NDDoH HIV.STD.Viral Hepatitis program.	Newly diagnosed viral hepatitis cases.	• Outbreak response plan developed.
Needed Resources/Gaps in Care Continuum/Challenges: None noted.				

Collaborations, Partnerships and Stakeholders

The NDDoH valued the contribution of many stakeholders during the development of this plan. The CPG was invaluable in the development of this plan. They determined the priority populations for this plan based on Epidemiologic Profile of HIV and hepatitis C in North Dakota. The NDDoH requested technical assistance from the National Alliance of State and Territorial AIDS Directors (NASTAD) to assist the CPG in objective setting and strategy development.

During the technical assistance provided to the NDDoH and the CPG, objectives, strategies and activities were determined. Representation from Indian Health Service was a key component of the objective development for this plan. Other individuals represented MSM, PLWH and other high-risk adults for HIV.

Not represented during this planning process were PWID. The NDDoH and CPG aim to develop partnerships with the North Dakota Department of Human Services (DHS) Division of Behavioral Health is the first year of this plan. In addition to DHS funded human service centers, there are additional privately ran substance abuse treatment facilities in which the NDDoH must facilitate outreach. One methadone clinic opened in August 2016 and another is projected to open in October 2016. Integrating HIV and viral hepatitis services at these facilities will be a high priority in 2017.

In addition to PWID, refugees were not well represented during the development of this plan. A new refugee coordinator was hired after the initiation of plan development. This coordinator has already agreed to become a member of the CPG in 2017. Refugees represent a significant proportion of the HIV epidemic in ND and the coordinator's input will be invaluable as North Dakota moves towards its goal of reducing the HIV and viral hepatitis epidemics.

Final approval of this plan occurred at a CPG meeting in September 2016. The co-chairs of the CPG approved a letter of concurrence (Appendix A).

People Living with HIV and Community Engagement

This HIV and Viral Hepatitis Prevention and Care Plan was developed to reflect the interests and needs of those representing the majority of the HIV and viral hepatitis epidemic in North Dakota.

Several PLWH were included in the planning process. The input of the PLWH provided many of the objectives in this plan. Facing stigma and an uneducated population were some of the main concerns PLWH have in North Dakota. Attempts were made to engage all PLWH in North Dakota through statewide meetings and a survey of Ryan White Clients. There is extremely limited participation of PLWH who are not Ryan White Clients or members of the CPG. This limited participation has does provide an adequate information on reasons for PLWH not engaged in care.

Engaging communities has not been a strong effort for the NDDoH and the CPG. Political restrictions and the conservative nature of North Dakota has made community engagement challenging. The CPG needs to take a leadership position in community education and mobilization.

SECTION III:
MONITORING AND IMPROVEMENT

Monitoring the Integrated HIV and Viral Hepatitis Prevention and Care Plan

Regular monitoring of the Integrated HIV and Viral Hepatitis Prevention and Care Plan is necessary to ensure progress is meaning made towards the completion of activities, goals and objectives.

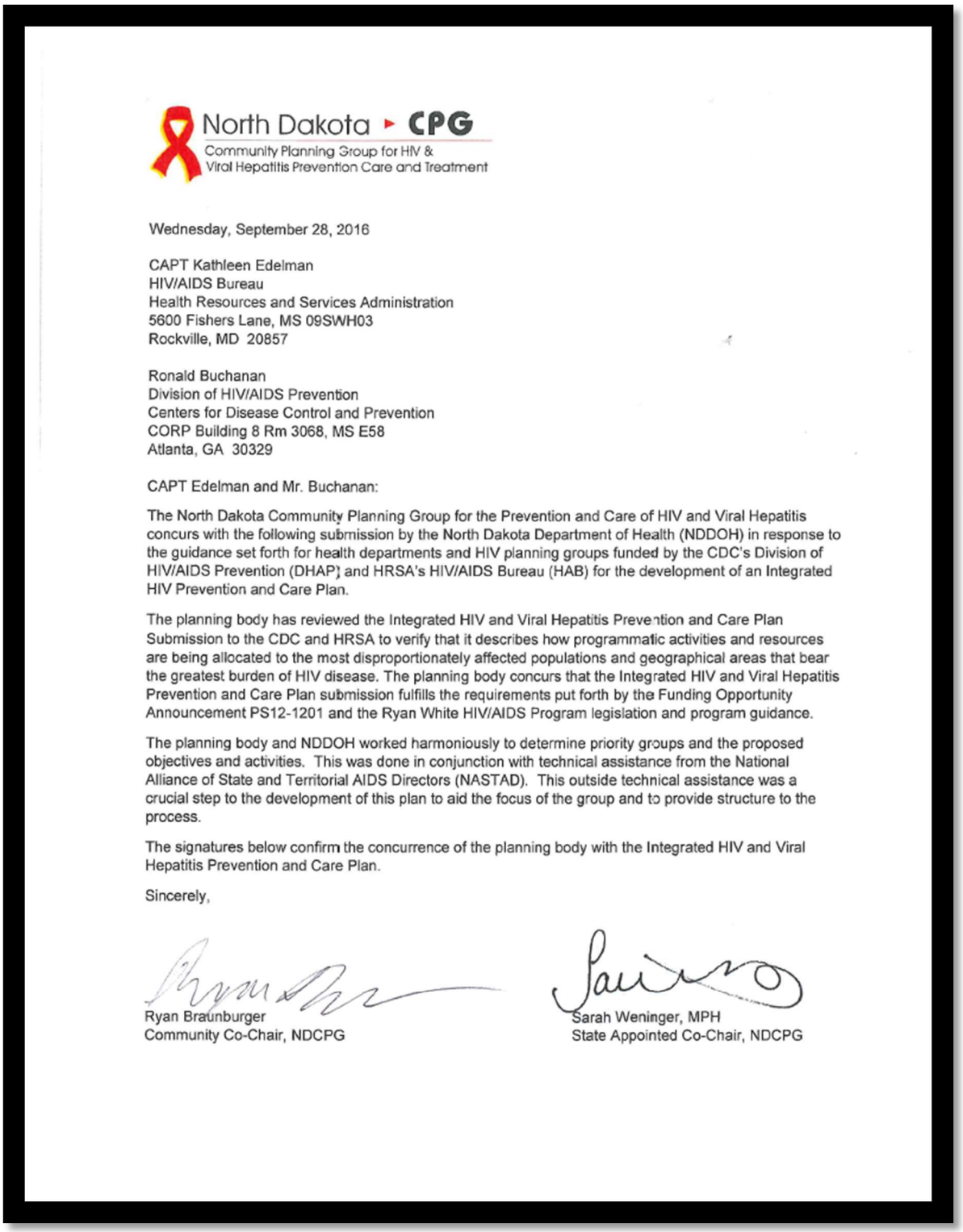
At every statewide CPG meeting, the HIV prevention coordinator shall prepare a standard report with the data indicators for each objective. This report will highlight successes and objectives that may need re-evaluation. Beginning in 2018, the first meeting CPG has each year will serve as the time to review current objectives and activities. If changes are needed, the CPG will re-establish objectives and activities once per year.

To solicit community input, the report of data indicators will be included in the Epidemiologic Profile that is published late spring of each year starting in 2018. The NDDoH aims to ensure that the Epidemiologic Profile is distributed to healthcare providers serving at-risk individuals and providing care to persons living with HIV or viral hepatitis.

To establish the data indicator report, the HIV.STD.Viral Hepatitis Prevention Coordinator will work the HIV.STD.Viral Hepatitis Surveillance Coordinator to ensure all required data is available. Surveillance data along with data from other sources such as testing data and available insurance data will be utilized to create this report.

In addition to creating a statewide report, reports will be created for individual healthcare providers that have a significant impact on the HIV and viral hepatitis care continuums. The HIV prevention coordinator and field epidemiologists will conduct clinical quality assurance activities including programmatic and administrative reviews of service providers to ensure service delivery quality. The NDDoH will work with healthcare providers on the development of quality improvement plans to ensure establish targets are meet or exceeded. These quality improvement plans will focus on goals and objectives that relate to improving outcomes along the HIV and viral hepatitis care continuum.

Appendix A: Letter of Concurrence between Planning Body and State Health Department



North Dakota ▸ CPG
Community Planning Group for HIV & Viral Hepatitis Prevention Care and Treatment

Wednesday, September 28, 2016

CAPT Kathleen Edelman
HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, MS 09SWH03
Rockville, MD 20857

Ronald Buchanan
Division of HIV/AIDS Prevention
Centers for Disease Control and Prevention
CORP Building 8 Rm 3068, MS E58
Atlanta, GA 30329

CAPT Edelman and Mr. Buchanan:

The North Dakota Community Planning Group for the Prevention and Care of HIV and Viral Hepatitis concurs with the following submission by the North Dakota Department of Health (NDDOH) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The planning body has reviewed the Integrated HIV and Viral Hepatitis Prevention and Care Plan Submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The planning body concurs that the Integrated HIV and Viral Hepatitis Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The planning body and NDDOH worked harmoniously to determine priority groups and the proposed objectives and activities. This was done in conjunction with technical assistance from the National Alliance of State and Territorial AIDS Directors (NASTAD). This outside technical assistance was a crucial step to the development of this plan to aid the focus of the group and to provide structure to the process.

The signatures below confirm the concurrence of the planning body with the Integrated HIV and Viral Hepatitis Prevention and Care Plan.

Sincerely,

Ryan Braunburger
Community Co-Chair, NDCPG

Sarah Weninger, MPH
State Appointed Co-Chair, NDCPG